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No.

In the Supreme Court of the United States

Term, 1995

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Petitioner

vs.

CAPITAL BLUE CROSS AND PENNSYLVANIA BLUE SHIELD,

Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

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(1) Because there is a conflict in the circuits as to whether a decedent, her Estate or her survivors' claims are preempted by ERISA, should Your Honorable Court decide this matter?

(2) Where a young woman died because her employer-provided health insurance refused to pay for lifesaving treatment, does ERISA, federal common law, or the Pennsylvania Bad Faith Insurance Statute provide her with a vehicle of redress?

(3) Where the Third Circuit followed neither its own precedent nor the Federal Rules of Civil Procedure in denying leave to amend, resulting in dismissal of this case, should the Petitioner have been permitted to amend her Complaint?

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PARTIES TO THE PROCEEDINGS

The only parties to the proceedings are those appearing in the caption of the case.

REFERENCE TO OPINIONS DELIVERED IN THE COURTS BELOW

On May 8, 1995, the United States Court of Appeals for the Third Circuit denied Erma Garner's Petition for Rehearing en Banc from its Judgment Order filed March 15, 1995. The March 15, 1995 Order affirmed the Order and Judgment of the United States District Court for the Middle District of Pennsylvania filed July 13, 1994, granting summary judgment in favor of the Defendants. The Third Circuit Decision is reported at 52 F.3d 314 (3rd Cir. 1995).

The District Court's Memorandum, Order and Judgment dated July 13, 1994, is reported at 859 F. Supp. 145 (M.D. Pa. 1994). The prior Decisions are reproduced in the Appendix, attached to this Petition for Writ of Certiorari.

STATEMENT OF JURISDICTION

Petitioner seeks review of the Third Circuit Court of Appeals Judgment Order entered March 15, 1995, and denial of her Petition for Rehearing entered Ma[illegible] 8, 1995, affirming the Decision of the United States District Court for the Middle District of Pennsylvania dated July 13, 1994, docketed to No. 1:CV-94-0218. The Petition for Writ of Certiorari was filed within ninety days of denial of the Petition for Rehearing. Jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

RELEVANT STATUTORY PROVISIONS

This case was held by the lower Courts to arise under the Employee Retirement Income Security Act of 1974 (ERISA) as amended, 29 U.S.C. §1001 *et seq.* Also implicated is Fed. R.Civ.P. 8.

CONCISE STATEMENT OF THE CASE

When Melissa Wileman was twenty years old, in June, 1992, she was diagnosed with inoperable liver cancer. Melissa worked in a sewing factory in rural Pennsylvania. Indeed, she and her mother, Erma Garner, both worked there. As part of the women's compensation, their employer purchased Blue Cross/Blue Shield health insurance. Blue Cross and Blue Shield paid Ms. Wileman's medical bills until January, 1993, when her doctors recommended an autologous bone marrow transplant and high dose chemotherapy. Blue Cross denied preauthorization, and Pittsburgh Cancer Institute refused to perform the procedure without a guarantee of payment.

After writing to their state congressman and Governor for help to no avail, Melissa and her mother went to an attorney. After the lawyer wrote *one letter,* Blue Cross agreed to pay for the expensive procedure. However, Missy had waited nearly six months to go to a lawyer. She was no longer a candidate for the treatment, and after three months of agony, she died on September 15, 1993.

Suit was brought for injunctive relief against Blue Cross and Blue Shield in July, 1993, along with another health insurer when it was learned that her employer switched health insurers on June 1, 1993, so no company claimed responsibility for her. Depositions of Missy's oncologist, her employer, her mother and of the young woman herself were taken in July and August, 1993. Although Melissa Wileman requested that her case be heard immediately, it was not. On September 15, 1993, Melissa Wileman, age twenty-one, died, never having had the opportunity of the bone marrow transplant that her doctors believed might have cured her.

Concise Statement of the Case

On January 21, 1994, suit was begun against Blue Cross and Blue Shield in state Court and subsequently removed to Federal Court on Defendants' Motion. After a Motion to Dismiss was denied, the Defendants filed a Motion for Summary Judgment. The Federal District Court for the Middle District of Pennsylvania, holding all of Plaintiff's claims preempted by the ERISA Statute, ruled that the Pennsylvania Bad Faith Insurance Statute was preempted, and dismissed the case.

The Third Circuit by Judgment Order dated March 16, 1995, affirmed the Trial Court's ruling, adding that Petitioner was not permitted to amend her Complaint because she waited "too long." Petition for Rehearing was denied on May 8, 1995.

ARGUMENT

A. Because There Is A Conflict In The Circuits As To Whether A Decedent, Her Estate Or Her Survivors' Claims Are Preempted By ERISA, Your Honorable Court Should Decide This Matter

The Fourth Circuit has held that in death cases, the Estate's survival action is preempted by ERISA, while the wrongful death action is not. The other circuits that have examined similar issues have held both wrongful death and survival actions to be preempted.[1] Only Your Honorable Court can resolve this conflict and assure that all claims are resolved evenhandedly.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" within its scope. 29 U.S.C. §1144(a). That phrase has been broadly interpreted. *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403 (1990). However, it is not absolute. As Your Honorable Court has recognized:

> "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."

Shaw v. Delta Airlines, 463 U.S. 85, 103 S.Ct. 2890 (1983). *See also, District of Columbia v. Greater Wash. Bd. of Trade*, 503

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[1] *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, U.S. , 113 S.Ct. 812 (1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Kuhl v. Lincoln Natl. Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, U.S. , 114 S.Ct. 694 (1994); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, U.S. , 114 S.Ct. 1612 (1994); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991); *Lafoy v. HMO Colorado*, 988 F.2d 97 (10th Cir. 1993).

U.S. 970, 112 S.Ct. 1584 (1992); *Powell v. Chesapeake and Potomac Tel. Co. of Virginia*, 780 F.2d 419, 421 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170, 106 S.Ct. 2892 (1986).

In *Liberty Corp. v. NCNB Nat. Bank of South Carolina*, 984 F.2d 1383 (4th Cir. 1993), the Court of Appeals held that the applicable state Wrongful Death Act "if it affects the Plan at all, does so in 'too tenuous, remote, or peripheral a manner' to warrant preemption." *Id.* at 1388. The Court examined the Wrongful Death and Survival Acts, holding that the former belongs to the decedent's beneficiaries, while the latter claim is of the decedent himself. Since the beneficiaries' claims under the Wrongful Death Act never belonged to the decedent, the Fourth Circuit held that state law action was not preempted by ERISA.

The Fourth Circuit case of *McInnis v. Provident Life & Acc. Ins. Co.*, 21 F.3d 586 (4th Cir. 1994) expands upon the view enunciated the year before. In *McInnis*, the Court emphasizes the differences between Wrongful Death Act and Survival Act claims:

> "The distinction between survival statutes and wrongful death statutes turns on the difference between those claims based on damages *preceding death* which were inflicted on and belonged to the decedent, and those claims based on damages *caused by* the decedent's death which belonged to family members."

Id. at 21 F.3d at 589. (Emphasis added.)

While Petitioner believes that claims of both the decedent and beneficiaries should be allowed to proceed, if Your Honorable Court adopts the reasoning of the Fourth Circuit, at least the Wrongful Death Act should be reinstated.

B. Where A Young Woman Died Because Her Employer-Provided Health Insurance Refused To Pay For Lifesaving Treatment, ERISA, Federal Common Law, Or The Pennsylvania Bad Faith Insurance Statute Should Provide Her With A Vehicle Of Redress

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The legislative intent of the ERISA Statute is explicitly enunciated:

> "... to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access in the Federal courts."

29 U.S.C. §1001(b).

Moreover, when the ERISA Statute was amended in 1989, the need for Federal Courts to be actively involved in fulfilling its purpose was acknowledged:

> "The Committee reaffirms the authority of the Federal courts to shape legal and equitable remedies to fit the facts and circumstances of the case before them, even though those remedies may not be specifically mentioned in ERISA itself. In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, the Committee intends the Federal Courts to develop a Federal common law of remedies, drawing upon principles enunciated in state law, includ-

> ing such remedies as the awarding of punitive and/or compensatory damages against the person responsible for the failure to pay claims in a timely manner."

H.R. Rep. No. 101-247, 101 St. Cong., 1st Sess. 55-56, *reprinted in* 1989 U.S.C.C.A.N. 1906, 1947-48.

Your Honorable Court recognized nearly a decade ago that when Congress enacted ERISA, it anticipated "that a Federal common law of rights and obligations under ERISA-regulated plans would develop." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987). No Court has yet fashioned Federal common-law rights and remedies to address the often-repeated scenario of an insurer denying lifesaving benefits and defending in the post-mortem action on the basis of ERISA preemption. To believe that such a result is intended under a statute designed to promote the interests of employees flies in the face of common sense, as well as prior Decisions of Your Honorable Court. *Shaw v. Delta Air Lines, supra.*

The Third Circuit in the case of *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993) held that a plan participant or beneficiary has a direct action for breach of fiduciary duty and is entitled to "other appropriate equitable relief" under the "Civil Enforcement" provisions of ERISA, 29 U.S.C. §1132(a)(3)(B). The Third Circuit noted:

> "Today we adopt the approach of Justice Brennan's concurrence in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed. 2d 96 (1985), and hold that 'Section 502(a)(3) authorizes the award of "appropriate equitable relief" directly to a participant or beneficiary to "redress" *"any* act or practice which violates *any* provision of this title" ' including a breach of the statutorily created fiduciary duty of an administrator. 473 U.S. at 153, 105 S.Ct. at 3096."

Id. at 1298. (Emphasis in original.)

In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985), the Supreme Court addressed only the question of whether an ERISA fiduciary could be held personally liable to a participant or beneficiary for extracontractual damages caused by the improper or untimely processing of benefit claims under §409(a), 29 U.S.C. §1109(a), and §502(a)(2), 29 U.S.C. §1132(a)(2). With regard to those limited sections, the United States Supreme Court held that Congress did not intend to authorize remedies for breach of fiduciary duty except for the plan. *Id.* at 144.

In his concurrence, joined by three other Justices, Justice Brennan wrote separately to emphasize the limited reach of the majority opinion and to outline the proper approach for Courts to take in construing other ERISA provisions. It is precisely this analysis that the Third Circuit has adopted as persuasive. *Bixler v. Central Pa., supra; Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226 (3d Cir. 1994).

In his concurring Opinion in *Massachusetts Mutual, supra* Justice Brennan notes the sweeping fiduciary duties articulated in the ERISA Statute. Section 404(a), 29 U.S.C. §1104(a), sets forth the governing standard for a fiduciary, requiring him to discharge his duties solely in the interests of the participants and beneficiaries and for the exclusive purpose of "providing benefits to participants and their beneficiaries." That section also provides that in carrying out his duties, a fiduciary shall exercise "the care, skill, prudence and diligence" of a "prudent man acting in a like capacity." As Justice Brennan pointed out, the legislative history demonstrates that Congress intended §404(a) to incorporate the fiduciary standards of trust law into ERISA. Surely, it is black letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits. Just as clearly, trust law remedies are equitable in nature, and they include provision for monetary damages. *Id.* at 153 fn.10.

Justice Brennan points out that §502(a)(3) of the Civil Enforcement section of the ERISA Statute, 29 U.S.C. §1132(a)(3), authorizes the award of "appropriate equitable relief" directly to a participant or beneficiary to "redress" "*any* act or practice which violates *any* provision of this title" or the terms of the plan. (Emphasis in original.) Justice Brennan concludes:

> "A beneficiary therefore may obtain 'appropriate equitable relief' whenever an administrator breaches the fiduciary duties set forth in §404(a). Accordingly, an administrator's claims-processing duties and a beneficiary's responding remedies are not at all necessarily limited to the terms of §§502(a)(1)(B) and 503. In light of the Court's narrow holding, see ante, at 3089, n.5, further consideration of these important issues remains open for another day when the disposition of a controversy might really turn on them."

Id. at 153 (footnotes omitted).

In the Third Circuit's adoption of this legal interpretation, the Court of Appeals notes as did Justice Brennan that §404(a) is basic to understanding the scope of an ERISA fiduciary's duties. The principles embodied in §404(a) are given effect by §502(a)(3). As the Third Circuit noted:

> "Allowing an injured beneficiary recourse through the courts is, furthermore, essential to fulfilling the purpose of ERISA."

Bixler, supra at 1299. *See also,* Decisions of other circuits to the same effect, at 1299 fn.17.

The Civil Enforcement provisions of the ERISA Statute, §502, 29 U.S.C. §1132, encompass a plethora of remedies available under ERISA. A participant or beneficiary is entitled "to recover benefits due to him under the terms of his plan, to

enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). These remedies stem from the fiduciary duties established within ERISA, §404(a)(1), 29 U.S.C. §1104(a)(1).

Assuming that the Defendants delay long enough, the claimant, like Melissa Wileman, will die. However, 29 U.S.C. §1132(a)(3)(B) in conjunction with the legislative history and intent of the statute authorizes the Courts to fashion fair remedies, including monetary damages. *Massachusetts Mutual, supra* at 153 fn.10. *See also, Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund, supra* and *Curcio v. John Hancock Mutual Life Insurance Company*, Nos. 93-7545, 93-7556 (3d Cir. 1994).

Moreover, §510 of the ERISA Statute, 29 U.S.C. §1140 provides for additional liability against the Defendants:

> "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan ... or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan. ... The provisions of section 502 shall be applicable to the enforcement of this section."

Section 510, 29 U.S.C. §1140.

Just as the Third Circuit has recognized the broad remedial purposes of ERISA and remedies available under it, so has the Sixth Circuit in the case of *Warren v. Society Nat. Bank*, 905 F.2d 975, 980 (6th Cir. 1990), *cert. denied*, 500 U.S. 952, 111 S.Ct. 2256 (1991).

In *Warren v. Society National Bank*, the Court of Appeals held that the provision permitting participants in ERISA plans

to obtain other appropriate equitable relief for violations of statute or terms of plan allows the recovery of monetary damages for plan trustees' breach of fiduciary duty. The Sixth Circuit held that the measure of damages to which the claimant was entitled under the ERISA Statute was the amount that would put him in the position he would have been in had the fiduciary *not* committed the breach of trust. The Court held that §502(a)(3) of ERISA, when construed with §404(a), provides for equitable remedies, including monetary damages.

The Court noted the factual differences in *Warren* and in *Massachusetts Mutual Life Insurance Co. v. Russell.* In the latter case, claim was asserted based upon §502(a)(2) rather than §502(a)(3). Moreover, the plaintiff in *Massachusetts Mutual* made no claim that the fiduciary of her disability plan violated a contractual duty. Instead, in *Massachusetts Mutual,* the plaintiff had received all the benefits to which she was entitled under the terms of the plan. In contrast, Dr. Warren brought his action pursuant to §502(a)(3) based on a cause of action under §404(a)(1). Relying on Justice Brennan's concurrence in *Massachusetts Mutual,* the Court concluded that "other appropriate equitable relief" for breach of fiduciary duties under §404(a) includes the imposition of monetary damages. *Id.* at 981. While it did not approve punitive damages, it held that the claimant did state a cause of action for the diminished value of his funds distributed in violation of his wishes, the immediate income tax consequences, and the loss over time of continued accumulation of tax-deferred retirement funds. Thus, the Sixth Circuit denied the defendant's motion to dismiss, holding that the amended complaint gave clear notice of the nature of the plaintiff's claims and their bases that were sufficient to withstand a Rule 12(b)(6) motion.

Moreover, a monetary award pursuant to §502(a)(3) can be based on equitable theories like unjust enrichment. *Provident Life & Acc. Ins. Co. v. Waller,* 906 F.2d 985, 992 (4th Cir.

1990), *cert. denied*, 498 U.S. 982, 111 S.Ct. 512 (1990). Unjust enrichment is a form of restitution developed in equity to force a party to disgorge benefits that it would be unjust for it to keep. Under the rationale of *Provident Life*, the Plaintiff should be entitled to recover not only her economic and non-economic losses but also the value of the benefits and additional money the Defendant has earned by wrongfully denying Melissa Wileman a bone marrow transplant and high dose chemotherapy.

Plaintiff believes that this position is not inconsistent with the holding of the Supreme Court in the recent case of *Mertens v. Hewitt Associates*, 113 S.Ct. 2063 (1993). The only issue that the Court decided in that case is whether the ERISA Statute authorizes suits for money damages against *non-fiduciaries* like the actuary sued in that action. The Supreme Court held that it does not. Such a Decision has no application to the instant action where a suit is brought against fiduciaries for breaches of their fiduciary duties.

The Third Circuit without comment held that ERISA's Insurance Savings Clause, 29 U.S.C. §1144(b)(2)(A) does not exempt the Pennsylvania Insurance Bad Faith Statute from preemption. The Pennsylvania Statute provides:

> "Actions on insurance policies
>
> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
>
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
>
> (2) Award punitive damages against the insurer.

(3) Assess court costs and attorney fees against the insurer."

42 Pa.C.S. §8371.

Plaintiff believes that *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985) mandates a finding that the Pennsylvania Bad Faith insurance law is not preempted by ERISA. The issue in *Metropolitan Life* was whether an insurer selling an insurance policy to an ERISA benefit plan engages in the business of insurance. Where the law spreads a policyholder's risk, the law is an integral part of the relationship between insurer and insured, and where the practice is limited to the insurance industry, the Savings Clause applies to protect state insurance regulations from preemption.

In the case of *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, U.S. , 114 S.Ct. 579 (1993), the Court looked at the effect of the Savings Clause on a Virginia Statute relating to insurance. As in this case, the Trial Court held that the ERISA preemption overrode the Savings Clause and, therefore, dismissed the action. The Fourth Circuit reversed. The Savings Clause states:

"nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. ..."

29 U.S.C. §1144(b)(2)(A).

Relying on the Supreme Court analysis in *Metropolitan Life Ins. Co. v. Massachusetts, supra*, the Fourth Circuit noted the two-part analysis to determine if the Savings Clause was effective with regard to a state law. The first was a commonsense approach, finding that the statute at issue regulated insurance contracts and logically should be encompassed by the "which regulates insurance" language of the Savings

Clause. Second, the Court examined the phrase "business of insurance" with respect to the McCarran-Ferguson Act, 15 U.S.C. §1011, *et seq.* In the latter, Congress was concerned with the type of state regulation that centers around the contract of insurance and the "relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the 'business of insurance'." *Metropolitan Life, supra* at 743-44. Moreover, as the Court emphasized in *Metropolitan Life,* if the law centers on an integral part of the policy relationship between the insurer and the insured, and is limited to the insurance industry, it is not preempted.

In *Stuart Circle Hospital Corp., supra,* the Court concluded that the Virginia Statute fit within the Savings Clause. Like the statute at issue in this case, it regulated the relationship between insurer and insured. It prohibited the insurer's "imprudent" and unreasonable actions, under the Pennsylvania Statute called "bad faith." In both a technical and a commonsense view, it regulated insurance dealings.

Thus, on this basis on which the Third Circuit remained silent, Petitioner asks that the dismissal of her Complaint be reversed.

C. Where The Third Circuit Followed Neither Its Own Precedent Or The Federal Rules Of Civil Procedure In Denying Leave To Amend, Resulting In Dismissal Of This Case, The Petitioner Should Have Been Permitted To Amend The Complaint

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Melissa Wileman died on September 15, 1993. This case was filed in January, 1994. On July 13, 1994, the Trial Court dismissed the case on Defendants' Motion for Summary Judgment under Fed. R.C.P. 56. By Judgment Order of March 15,

1995, the Third Circuit affirmed, holding Plaintiff's claims preempted by ERISA and denying her leave to amend in that it was requested "too late." Slip Op. p. 2.

Amendment under Fed. R.C.P. 15(a) is to be liberally granted and denied only where there is evidence of substantial prejudice, bad faith or dilatory motives. *Lorenz v. CSX Corp.*, 1 F.3d 1406 (3d Cir. 1993). Delay alone in requesting permission to amend is insufficient to warrant denying amendment. *Adams v. Gould, Inc.*, 739 F.2d 858 (3d. Cir. 1984), *cert. denied*, 469 U.S. 1122, 105 S.Ct. 806 (1985). Amendment is allowed up through trial where justice requires. If amendment would allow the Plaintiff to go forward with her action, it should be granted. To do otherwise *is antithetical to notions of fairness. Howze v. Jones & Laughlin Steel Corp.*, 750 F.2d 1208 (3d Cir. 1984). This is especially true in light of the fact that the statute of limitations has not yet run on this case that has been on appeal for a year.

Moreover, our Federal Courts adhere to notice pleading. Surely, Plaintiff's Amended Complaint, consisting of twenty pages of ninety-three paragraphs, apprises the Defendants of the material facts in this matter. Further, this is the second action brought against them arising out of the same facts. Under Fed. R.C.P. 8(a)(2), a complaint has been deemed to be sufficient if it provides notice to the Defendants of the essential elements of the cause of action. *Holder v. City of Allentown*, 987 F.2d 188 (3d. Cir. 1993).

CONCLUSION

It is incongruous that the bestseller *The Rainmaker* by John Grisham deals with nearly identical facts but a private insurance policy, an understanding judge and state law. The difference in results cannot be justified nor can employees bargaining for health benefits continue to be treated differently from individuals who buy their own medical insurance directly.

Respectfully submitted,
ANGINO & ROVNER, P.C.
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**Counsel of Record*

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

NO. 94-7473

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Appellant,

v.

CAPITAL BLUE CROSS; PENNSYLVANIA BLUE SHIELD

Appeal from the United States District Court for the Middle District of Pennsylvania
(D.C. Civil Action No. 94-cv-00218)
(District Judge: Hon. William W. Caldwell)

Argued on January 31, 1995

BEFORE: SCIRICA, ROTH, and SAROKIN, Circuit Court Judges

JUDGMENT ORDER

After consideration of all contentions raised by appellant, that:

1. The trial court erred in holding that the ERISA Statute controlled this action; and

2. The trial court erred in granting appellees' motions for summary judgment, dismissing this action brought to seek redress for the death of Melissa Wileman because of the appellees' refusal to agree to pay the costs of an autologous bone marrow transplant until after Melissa Wileman was no longer a candidate for such a transplant. Appellant alleges that the trial court should have found that

a. appellant has a claim against appellees for breach of fiduciary duty;

b. appellant has a remedy of "appropriate equitable relief under 29 U.S.C. §1132(a)(3)(B);

c. the Pennsylvania bad faith insurance statute, 42 P.S. §8371, is exempt from ERISA preemption; and

d. appellant should have been given a further opportunity to amend her complaint.

We hold that appellant's claim is preempted by ERISA and thus we do not need to consider the state law issues raised by appellant.[1] We further find that, although appellant was informed of appellees' position that ERISA preempted her claims and although appellant was given an opportunity by the District Court to amend her complaint, she chose not to plead an ERISA claim. Her request now at the appellate level to amend her complaint to plead an ERISA cause of action comes too late.

IT IS ADJUDGED AND ORDERED that the judgment of the district court entered July 13, 1994, be and is hereby affirmed.

Costs to be taxed against appellant.

BY THE COURT,
/s/Roth
Circuit Judge

Attest:
/s/P. Douglas Sisk, Clerk

DATED: MAR 15 1995

---

[1] Because Melissa Wileman did not seek a remedy under 29 U.S.C. §1132(a) for denial of benefits due to her under the terms of her ERISA plan, we also do not have to, under the circumstances of this case, consider the issue, which was alluded to by appellant that monetary damages should be available under ERISA on a claim that the insurance carrier for an ERISA medical or hospital plan wrongfully failed to pay benefits which were due to a beneficiary under the terms of that plan.

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

NO. 94-7473

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Appellant,

v.

CAPITAL BLUE CROSS; PENNSYLVANIA BLUE SHIELD

BEFORE: SLOVITER, Chief Judge, BECKER, STAPLETON MANSMANN, GREENBERG, HUTCHINSON, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, LEWIS, McKEE and SAROKIN, Circuit Judges

SUR PETITION FOR REHEARING IN BANC

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participatede* in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court *in banc*, the petition for rehearing is denied.

BY THE COURT,
/s/Roth
Circuit Judge

DATED: MAY 08 1995

Erma GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased, Plaintiff,

v.

CAPITAL BLUE CROSS and Pennsylvania Blue Shield, Defendants.

Civ. A. No. 1:CV-94-0218.

United States District Court,

M.D. Pennsylvania.

July 13, 1994.

Employee welfare benefit plan participant's mother brought action, individually and as administratrix of participant's estate, against health insurers in state court arising out of denial of benefits. Action was removed. Insurers moved for summary judgment. The District Court, Caldwell, J., held that: (1) ERISA preempted claims for negligence, negligent or intentional infliction of emotional distress, bad faith denial of claim, fraud, violation of covenants of good faith and fair dealing, wrongful death, and survival, and (2) count alleging that insurers breached contracts of insurance would not be construed as an ERISA claim.

Motions granted.

1. Pensions 22
States 18.51

Count of amended complaint alleging that health insurers acted negligently with respect to insured under employee welfare benefit plan asserted state law claim of negligence which was preempted by ERISA. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

2. Damages 49.10, 50.10
Pensions 22
States 18.15, 18.51

State law causes of action against health insurers for negligent and intentional infliction of emotional distress were preempted by ERISA. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

3. Damages 49.10
Pensions 22
States 18.15, 18.51

Fact that a party other than employee welfare benefit plan participant claimed emotional distress did not preserve claim from preemption by ERISA as actions of which participant complained were denial of benefits and, thus, the claim related to ERISA plan. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

4. Pensions 22

State law claim that health insurers denied employee welfare benefit plan participant's claim in bad faith was preempted by ERISA. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144; 42 Pa.C.S.A. §8371.

5. Pensions 22
States 18.15, 18.51

State law fraud cause of action against health insurers under employee welfare benefit plan was preempted by ERISA. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144; 42 Pa.C.S.A. §8371.

6. Pensions 22
States 18.51

ERISA preempted state law claims against health insurers under employee welfare benefit plan for alleged violations

of covenants of good faith and fair dealing and wrongful death. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

7. Pensions 22
States 18.15

State survival action against health insurers arose out of insurers' decision regarding employee welfare benefit plan participant's claim; thus, it related to ERISA plan and was preempted by ERISA. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

8. Pensions 22
States 18.51

ERISA preempts state actions for breach of contract. Employee Retirement Income Security Act of 1974, §514, as amended, 29 U.S.C.A. §1144.

9. Pensions 139

To the extent that employee benefit plan participant's mother and administratrix of participant's estate sought to have district court construe her claim against health insurers for breach of contracts of insurance as an ERISA action, district court declined to do so; ERISA was an equitable statute but claim sought money damages, because mother did not actually incur medical expenses, restitution would have been appropriate, and because plan participant did not survive, any request for injunction would have been moot. Employee Retirement Income Security Act of 1974, §§2 et seq., 502, as amended, 29 U.S.C.A. §§1001 et seq., 1132.

Pamela Green Shuman, Angino & Rovner, P.C., Harrisburg, PA, for plaintiffs.

James J. Kutz, Eckert, Seamans, Cherin & Mellott, Douglas J. Davison, Harrisburg, PA, for defendant Capital Blue Cross.

Randall Glenn Gale, Thomas, Thomas & Hafer, Harrisburg, PA, for defendant Pennsylvania Blue Shield.

MEMORANDUM

CALDWELL, District Judge.

We are considering the motions for summary judgment filed by Defendants, Capital Blue Cross ("Blue Cross") and Pennsylvania Blue Shield ("Blue Shield"). We exercise jurisdiction according to 28 U.S.C. §§1331 and 1332.

I. *Facts and Procedural History*

This case arises from the death of Melissa Wileman, a young woman who was diagnosed in June, 1992, with peripheral neuroectodermal cancer.[1] Physicians placed Ms. Wileman on chemotherapy and the treatment decreased the size of her tumor by nearly 70 per cent. Her physicians suggested that her only remaining opportunity to entirely eliminate the cancer was to undergo a bone-marrow transplant.

Ms. Wileman was employed by Lyon Fashions, Inc. ("Lyon"), a clothing manufacturer based in Pennsylvania. Defendant Capital Blue Cross provided benefits to Lyon employees. *See* Plan, Exh. A to the Amended Complaint. Capital Blue Cross initially declined to precertify the procedure, determining that it was experimental and, therefore, not covered by the Lyon policy. After receiving communication from the Pennsylvania Insurance Department and Ms. Wileman's counsel, Blue Cross reconsidered its earlier position and indicated to Ms. Wileman's counsel that it would pay for the treatment. It asserted that its decision was based on an exception in the plan and that it continued to believe its earlier refusal was correct. *See* Letter of 6/18/93 from Mary Jane Forbes to Pamela G. Shuman, Esq. However, while preparing for the bone-marrow transplant in June, 1993, doctors determined that Ms. Wile-

1. We draw our description of the facts from the complaint.

man was too weak to undergo the procedure. Ms. Wileman died on September 15, 1993.

On January 21, 1994, Plaintiff Erma Garner, individually as Ms. Wileman's mother and as administratrix of her daughter's estate, filed a complaint in the Court of Common Pleas of Dauphin County, Pennsylvania. She alleged causes of action against Blue Cross and Blue Shield. By notice of February 14, 1994, Defendants removed the case, asserting that it falls within the ambit of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* Plaintiff moved to remand and Defendants moved to dismiss and we denied the motions in our Memorandum and Order of April 15, 1994. We also permitted Plaintiff the opportunity to amend her complaint so that it might more clearly set forth her causes of action. Plaintiff filed an amended complaint on April 29, 1994, and both Defendants have moved for summary judgment, asserting that the causes of action plead• by the amended complaint are preempted by ERISA.

II. *Law and Discussion*

A. *The Amended Complaint*

In our Memorandum and Order of April 15, 1994, we suggested that Plaintiff amend her complaint to "more clearly indicate which causes of action she is pursuing." As Blue Cross notes in its brief, the amended complaint is plead in the same manner as the original complaint and we agree with Defendants that the amended complaint is confusing. It sets out eight "counts" and four "claims." The "counts" only obliquely indicate the asserted causes of action while the "claims" are labeled "wrongful death," "survival action," "bad faith," and "emotional distress." We are unfamiliar with this pleading technique and share Defendants' concerns. In defending against a complaint, a defendant must be able to readily determine what is alleged. Here, Defendants (and the Court)

are left to guess what Plaintiff intends to assert, particularly because several of the "counts" and "claims" appear to be duplicative. For example, Count III avers

> 50. The Defendants are responsible for the negligent and/or intentional infliction of emotional distress suffered by both Melissa Wileman and Erma Garner based upon their contemporary sensory perceptions of the Defendants' negligent denial and/or delay in granting pre-authorization for Melissa Wileman's bone marrow transplant.

Claim IV avers

> 93. Based upon the negligent and/or intentional infliction of emotional distress, Plaintiffs are entitled to compensation from the Defendants for the emotional distress suffered plus punitive damages, attorney's fees and costs.

These assertions appear to be redundant, as are Count IV and Claim III (bad faith) and Count II and Count VII (negligence).[2]

A complaint which is prolix or confusing makes it difficult for a defendant to fairly defend and it unnecessarily erects hurdles to an orderly and efficient disposition of the case. *See Vicom Inc. v. Harbridge Merchant Services, Inc.*, 20 F.3d 771, 776 (7th Cir.1994). Indeed, some courts have dismissed such complaints for failure to comply with Fed.R.Civ.P. 8(a) and (e). *See Alfano v. Whitmore*, No. 79 C 5394 (N.D. Ill. April 29, 1980). We are not inclined to take such this* action, although we must conclude that Plaintiff did not heed the message in our Memorandum and Order of April 15,1994. We will con-

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[2] Counts VII and VIII seem to allege some variations of negligent or intentional infliction of emotional distress. Count VII could be construed to assert a negligence claim.

sider the motions for summary judgment and revisit the pleading issue if necessary.

B. *The Motions for Summary Judgment*

Summary judgment is appropriate when there remain no genuine issues as to any material facts and judgment may be entered as a matter of law. Fed.R.Civ.P. 56; *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). When a movant submits that there is no genuine issue as to a material fact, its opponent must do more than "simply show that there is some metaphysical doubt as to the material facts." *Matsushita Electric Industrial Co., Ltd., et al. v. Zenith Radio Corp. et al.*, 475 U.S. 574, 586, 106 S.Ct. 1348, 1356, 89 L.Ed.2d 538 (1986).

Defendants argue that the employee-benefit plan offered by Ms. Wileman's employer, Lyon Fashion, Inc., is governed by ERISA. With the exception of her previously filed motion to remand, Plaintiff does not deny that conclusion. *See* 29 U.S.C. §1003(a)(1).

1. *Preemption*

The crux of the current motions is Defendants' argument that all of the allegations of the amended complaint recite state-law causes of action that are preempted by ERISA. *See* 29 U.S.C. §1144(a).

In enacting ERISA, Congress included a broad preemption of state law claims:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and

not exempt under section 1003(b) of this title. This section shall take effect January 1, 1975.

(b) Construction and application

•••

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

•••

(B) Neither an employee benefit plan described in section 1003(a) of this title ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer ... for purposes of any law of any State purporting to regulate insurance companies ...

29 U.S.C. §1144. A number of United States Supreme Court decisions have construed the ERISA preemption clause. The Court has held that the enforcement provisions of ERISA are sufficiently broad to indicate a congressional intent that almost all state-law claims be preempted. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). Section 1144(b)(2)(A), known as the "saver" clause, works to allow certain state insurance laws to survive the ERISA preemption. *Metropolitan Life Insur. Co. v. Massachusetts*, 471 U.S. 724, 732, 105 S.Ct. 2380, 2385, 85 L.Ed.2d 728 (1985). However, the exception provided by the "saver" clause is itself limited by §1144(b)(2)(B), which is known as the "deemer" clause because it deems certain benefit plans not to be insurance plans subject to state regulation and, therefore, not "saved" from ERISA preemption. The Court recently delineated which benefit plans qualify for the "deemer" clause exemption. *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990). The Court held that the deemer

clause exempts self-funded ERISA plans from state laws regulating insurance. *Id.*, 498 U.S. at 60, 111 S.Ct. at 409, 112 L.Ed.2d at 366. The Supreme Court has also held that other state-law or common-law claims are preempted by ERISA. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

2. *Count II*

[1] Count II of the amended complaint asserts that

> 43. Defendants Capital Blue Cross and Pennsylvania Blue Shield acted negligently with respect to Melissa Wileman by ...

We construe this to assert a claim of negligence. As such, we find that it is preempted by 29 U.S.C. §1144 and we will grant judgment on that count.[3]

3. *Counts III, VII, and VIII, and Claim IV*

[2,3] Counts III, VII, and VIII and Claim IV appear to assert causes of action for negligent or intentional infliction of emotional distress. These claims as well are preempted. *Pane v. RCA Corp.*, 868 F.2d 631, 635 (3d Cir.1989).[4]

4. *Count IV and Claim III*

[4] Count IV and Claim III assert that Defendants denied Ms. Wileman's claim in bad faith. *See* 42 Pa.Cons.Stat. §8371. While the United States Court of Appeals for the Third Circuit has not addressed the issue of whether ERISA preempts such

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3. Although we will discuss Count VII later in this Memorandum, we note that, to the extent that it makes a negligence claim, it is preempted.

4. These allegations also assert that Ms. Wileman's mother suffered severe emotional distress. The fact that a party other than the plan participant claims emotional distress does not preserve the claims from preemption. *See Kuhl v. Lincoln Natiotial Health Plan*, 999 F.2d 298, 303-04 (8th Cir.1993). The actions of which she complains were the denial of benefits and, thus, the claim "relates to" an ERISA plan. *Id.* Put another way, Mrs. Garner's emotional distress would stem from the claim denial.

a claim, we agree with the numerous district courts that have found such claims preempted. *See Rallis v. Trans World Music Corp.*, No. 93-6100, 1994 WL 96264 at *4 (E.D.Pa. March 25, 1994) (collecting cases). Thus, we find Count IV and Claim III preempted.

5. *Count V*

[5] Count V asserts a cause of action for fraud. Again, such a common-law claim is preempted. *See Elmore v. Cone Mills Corp., et al.*, 23 F.3d 855 (4th Cir.1994); *Glasgow v. Ken J. Pezrow Corp., et al.*, No. 91-1528, 1991 WL 209799 at *1, 1991 U.S.Dist. LEXIS 14643 at *2 (E.D.Pa. Oct. 9, 1991).

6. *Count VI*

[6] Count VI alleges that Defendants violated their covenants of good faith and fair dealing by denying Ms. Wileman's claim. Such claims are preempted by ERISA. *Pane*, 868 F.2d at 635.

7. *Claim I*

Claim I asserts a cause of action for wrongful death. ERISA preempts wrongful death claims. *See Kolb v. Livengrin Foundation, Inc.*, No. 92-01703, 1992 WL 333592 at *5 (E.D.Pa. Nov. 9, 1992).

8. *Claim II*

[7] Claim II is a survival action brought on behalf of the estate of Ms. Wileman according to 42 Pa.Cons.Stat.Ann. §8302. As with the other common-law or state-law claims, any cause of action here would arise from Defendants' decision regarding Ms. Wileman's claim. Thus, it relates to an ERISA plan and is preempted by the federal statute. *See Dukes v. United States Health Care Systems of Pennsylvania, Inc.*, 848 F.Supp. 39, 41 (E.D.Pa. 1994). We will dismiss Claim II.

9. *Count I*

We have reserved our examination of Count I until we considered the other parts of the complaint. Count I is the heart of this complaint and it is, in some ways, the most troubling.

[8,9] Count I clearly contains language sounding in contract law.

> 40. Defendants Capital Blue Cross and Pennsylvania Blue Shield breached their contracts of insurance with Melissa Wileman by ...

ERISA preempts actions for breach of contract. *Pilot Life*, 481 U.S. at 45, 107 S.Ct. at 1552; *see also, Booz v. Unum Life Insurance Co.*, No. 93-2326, 1993 WL 313372 at *1 (E.D.Pa. July 29, 1993). We are reluctant, however, to assume that Plaintiff means to assert a common-law breach of contract claim rather than an ERISA claim under 29 U.S.C. §1132.[5]

In reviewing a motion such as this, we are to view the complaint in the light most favorable to the plaintiff. Here, Plaintiff avers that

> [Defendants breached the contract of insurance by] ... acting in an arbitrary and capricious manner in denying and/or delaying pre-authorization for Melissa Wileman's bone marrow transplant ...

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5. Plaintiff argues at length about the merits of the case; *i.e.*, whether the procedure requested was, actually, experimental. That issue is not now before the Court. A preemption argument does not implicate the substance of a claim. Further, it is not clear why, at this stage of the litigation, Plaintiff cites *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993). *Bixler* dealt with the availability of certain causes of action within ERISA. Here, Plaintiff contends that Ms. Wileman was due certain benefits of the insurance plan. Such an action is certainly recognized within ERISA. *See* 29 U.S.C. §1332. The question here is whether Plaintiff has plead* a common-law breach-of-contract claim (which would be preempted) or a proper ERISA claim.

Amended Complaint at ¶ 40. A district court should approach an ERISA case bearing in mind the broad purposes of ERISA. *Bixler, supra.* Nevertheless, we must agree with Defendants that Plaintiff has failed to properly plead an ERISA case.

ERISA is, in large measure, an equitable statute. *Mertens v. Hewitt Associates,* U.S. , 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993). As such, its civil remedies provisions contemplates equitable actions such as injunctions, restitution, and mandamus. U.S. at - , 113 S.Ct. at 2064-66, 124 L.Ed.2d at 165-66. Those provisions do not provide for awards of money damages. *Id.* Importantly, Plaintiff's claim, sounding as it does in contract law, seeks damages. Because Plaintiff did not actually incur medical expenses, restitution would be inappropriate and, because Ms. Wileman did not survive, any request for an injunction would be moot.[6]

To the extent that Plaintiff seeks to have the court construe her claim as an ERISA action, we decline. Plaintiff has neither sought, nor been granted, leave to amend her complaint. Fed.R.Civ.P. 15. She has, however, already had the opportunity to amend her complaint to plead an ERISA case in this court and has not done so. To either construe her claim as an ERISA claim or to allow her to amend at this late date would prejudice the Defendants. Further, as noted, ERISA does not contemplate an action such as that brought here. Thus, any amendment would be subject to a motion to dismiss. *Unger v. Nat'l Residence Matching Program,* 928 F.2d 1392 (3d Cir. 1991).

Given these two conclusions, we will grant summary judgment as well on Count I.

We will issue an appropriate order.

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[6] We are not unaware that medical providers often decline to render expensive treatment unless it is guaranteed by an insurer. The injunctive relief available under ERISA was almost certainly, in part, intended to address that situation.

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Plaintiff

vs.

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD, Defendants

CIVIL ACTION NO. 1:CV-94-0218

ORDER AND JUDGMENT

AND NOW, this 13th day of July, 1994, upon consideration of Defendants' motions for summary judgment, it is ordered that:

1. The motions are granted.

2. Judgment is entered in favor of Defendants and against Plaintiff.

3. The Clerk of Court shall close this file.

/s/William W. Caldwell
United States District Judge

§1001. Congressional findings and declaration of policy

***

(b) Protection of Interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

***

§1001b. Additional Congressional findings and declaration of policy; single-employer plan termination insurance system

(a) Findings

The Congress finds that—

(1) single-employer defined benefit pension plans have a substantial impact on interstate commerce and are affected with a national interest;

(2) the continued well-being and retirement income security of millions of workers, retirees, and their dependents are directly affected by such plans;

(3) the existence of a sound termination insurance system is fundamental to the retirement income security of participants and beneficiaries of such plans; and

(4) the current termination insurance system in some instances encourages employers to terminate pension plans, evade their obligations to pay benefits, and shift unfunded pension liabilities onto the termination insurance system and the other premium-payers.

(b) Additional findings

The Congress further finds that modification of the current termination insurance system and an increase in the insurance premium for single-employer defined benefit pension plans—

(1) is desirable to increase the likelihood that full benefits will be paid to participants and beneficiaries of such plans;

(2) is desirable to provide for the transfer of liabilities to the termination insurance system only in cases of severe hardship;

(3) is necessary to maintain the premium costs of such system at a reasonable level; and

(4) is necessary to finance properly current funding deficiencies and future obligations of the single-employer pension plan termination insurance system.

***

§1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1003(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

***

§1109. Liability for breach of fiduciary duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

***

§1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respct[1] to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Administrator's refusal to supply requested information

Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such

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[1] So in original. Probably should be "respect".

request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena,* or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan of an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and

process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved (as defined in section 4975(f)(4) of Title 26); except that if the transaction is not corrected (in such manner as the Secretary shall prescribe by regulation, which regulations shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a

transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(Pub.L. 93—406. Title I, §502, Sept. 2, 1974, 88 Stat. 891; Pub.L. 96—364, Title III, §306(b), Sept. 26, 1980, 94 Stat. 1295.)

•••

§1140. Interference with protected rights

It shall be unlawful for any person to discharge, fine, suspend, expel discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act [29 U.S.C.A. §301 et seq.], or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan,

this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter or the Welfare and Pension Plans Disclosure Act. The provisions of section 1132 of this title shall be applicable in the enforcement of this section.

(Pub.L. 93—406, Title I, §510, Sept. 2, 1974, 88 Stat. 895.)

***

§1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance

company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

Rule 8. General Rules of Pleading

(a) Claims for Relief. A pleading which sets forth a claim for relief, whether an original claim, counterclaim, cross-claim, or third-party claim, shall contain (1) a short and plain statement of the grounds upon which the court's jurisdiction depends, unless the court already has jurisdiction and the claim needs no new grounds of jurisdiction to support it, (2) a short and plain statement of the claim showing that the pleader is entitled to relief, and (3) a demand for judgment for the relief the pleader seeks. Relief in the alternative or of several different types may be demanded.

(b) Defenses; Form of Denials. A party shall state in short and plain terms the party's defenses to each claim asserted and shall admit or deny the averments upon which the adverse party relies. If a party is without knowledge or information sufficient to form a belief as to the truth of an averment, the party shall so state and this has the effect of a denial. Denials shall fairly meet the substance of the averments denied. When a pleader intends in good faith to deny only a part or a qualification of an averment, the pleader shall specify so much of it as is true and material and shall deny only the remainder. Unless the pleader intends in good faith to controvert all the averments of the preceding pleading, the pleader may make denials as specific denials of designated averments or paragraphs or may generally deny all the averments except

such designated averments or paragraphs as the pleader expressly admits; but, when the pleader does so intend to controvert all its averments, including averments of the grounds upon which the court's jurisdiction depends, the pleader may do so by general denial subject to the obligations set forth in Rule 11.

(c) Affirmative Defenses. In pleading to a preceding pleading, a party shall set forth affirmatively accord and satisfaction, arbitration and award, assumption of risk, contributory negligence, discharge in bankruptcy, duress, estoppel, failure of consideration, fraud, illegality, injury by fellow servant, laches, license, payment, release, res judicata, statute of frauds, statute of limitations, waiver, and any other matter constituting an avoidance or affirmative defense. When a party has mistakenly designated a defense as a counterclaim or a counterclaim as a defense, the court on terms, if justice so requires, shall treat the pleading as if there had been a proper designation.

(d) Effect of Failure to Deny. Averments in a pleading to which a responsive pleading is required, other than those as to the amount of damage, are admitted when not denied in the responsive pleading. Averments in a pleading to which no responsive pleading is required or permitted shall be taken as denied or avoided.

(e) Pleading to be Concise and Direct; Consistency.

(1) Each averment of a pleading shall be simple, concise, and direct. No technical forms of pleading or motions are required.

(2) A party may set forth two or more statements of a claim or defense alternately or hypothetically, either in one count or defense or in separate counts or defenses. When two or more statements are made in the alternative and one of them if made independently would be suffi-

cient, the pleading is not made insufficient by the insufficiency of one or more of the alternative statements. A party may also state as many separate claims or defenses as the party has regardless of consistency and whether based on legal, equitable, or maritime grounds. All statements shall be made subject to the obligations set forth in Rule 11.

(f) Construction of Pleadings. All pleadings shall be so construed as to do substantial justice.

(As amended Feb. 28, 1966, eff. July 1, 1966; Mar. 2, 1987, eff. Aug. 1, 1987.)

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*Errata in original.

(2)

Supreme Court, U.S.
FILED
AUG 31 1995
CLERK

No. 95-204

In The

Supreme Court of the United States

October Term, 1995

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Petitioner,

vs.

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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QUESTION PRESENTED FOR REVIEW

1. Whether the Court of Appeals correctly affirmed an order of the district court granting summary judgment against an ERISA plan beneficiary who, although governed by ERISA and its exclusive remedial scheme, nevertheless insisted upon advancing only state law claims seeking money damages, despite numerous opportunities afforded to her to amend her Complaint to plead an ERISA claim and despite warnings from both the district court and Respondents that her state law claims were subject to dismissal because of ERISA's preemption?

LIST OF PARTIES

Pursuant to Rule 29.1, Respondent Capital Blue Cross identifies the following subsidiaries: Keystone Health Plan Central, Inc., Health Benefits Management, Inc., Comp 1, Shared Services Center and Pennsylvania Medical Management Inc.

Additionally, Respondent Pennsylvania Blue Shield identifies the following subsidiaries: Keystone Health Plan Central, Inc., Health Benefits Management, Inc., Keystone Health Plan East, Inc., Comp Services, Inc., Inter-County Health Plan, Inc., Inter-County Hospitalization Plan, Inc., Blair Mill Administrators, Inc. and Keystone Health Plan West, Inc.

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OPINIONS BELOW

Respondents accept the Petitioner's "Reference to Opinions Delivered in the Courts Below".

STATEMENT OF JURISDICTION

On March 15, 1995, the United States Court of Appeals for the Third Circuit issued a Judgment Order which affirmed a July 13, 1994 Order of the district court granting summary judgment in favor of Respondents. A Petition for Rehearing was denied on May 8, 1995. The Petition for Writ of Certiorari was filed on August 4, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This appeal involves one federal statute, one state statute, and two Rules of Civil Procedure. First, it involves the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA"). Second, it involves Pennsylvania's "bad faith" insurance statute, 42 Pa. C.S. § 8371. Finally, it involves Federal Rule of Civil Procedure 15, which relates to amendments to pleadings, and Rule 56 which relates to motions for summary judgment and opposition thereto.[1]

STATEMENT OF THE CASE

A. Introduction

Petitioner seeks a Writ of Certiorari to review a March 15, 1995 order of the United States Court of Appeals for the Third

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1. The verbatim text of 42 Pa. C.S. § 8371, as well as Rule 15 and Rule 56 appear in Respondents' Appendix at 1a-6a. Pertinent provisions of ERISA appear in Petitioner's Appendix at 17a-29a.

Circuit which affirmed an order of the United States District Court for the Middle District of Pennsylvania entered July 13, 1994, granting Respondents' Joint Motions for Summary Judgment as to each of the several state law claims advanced by Petitioner in an amended complaint. This entire controversy arises out of the basic contention that Respondents breached their obligations under the terms of an employee benefit plan by refusing to pre-authorize the payment for a medical procedure which Petitioner's decedent desired.

Rather than proceeding under the provisions of ERISA, Petitioner sought money damages under several state law theories. Now, on appeal to this Court, Petitioner asserts that a Writ should be granted to address three separate legal questions. Those questions relate to, *inter alia*, (a) when leave to amend may be granted pursuant to Rule 15, Fed.R.Civ.P.; (b) ERISA's preemption of state law claims; and (c) an alleged conflict among the Circuits relating to ERISA's preemption of state law claims.[2]

For the reasons which follow, there are no special or important reasons why the Petition should be granted, and there is no conflict among the Circuits concerning the matter pending before this Court. The Petition should therefore be denied.

B. Procedural History and Relevant Facts[3]

Erma Gamer ("Petitioner") is the mother of, and Administratrix of the Estate of, Melissa Wileman ("Wileman"), a young woman who, until May 31, 1993, was employed by Lyon

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2. As discussed more fully in section 5 of the Argument, Petitioner argues that a conflict exists as to whether her state "wrongful death" claim is preempted by ERISA.

3. Because Petitioner's Statement of the Case does not present fairly that which occurred below, and because many of Petitioner's arguments relate to alleged procedural violations by the courts below, the following history and statement of relevant facts is provided.

Fashion, Inc. ("Lyon") in the Commonwealth of Pennsylvania. Sometime during calendar year 1992, Wileman, then an employee of Lyon, was diagnosed with peripheral neuroectodermal cancer. She received traditional chemotherapy until early 1993 when she was referred by her oncologist to the Pittsburgh Cancer Institute, where it was recommended that she undergo a procedure known as an autologous bone marrow transplant ("ABMT") with high dose chemotherapy ("HDC"). *See* Garner amended complaint at ¶¶ 8-9, Respondents' Appendix at 18a-19a.[4] At the time of this referral in February of 1993, Wileman, as an employee of Lyon, was a beneficiary under an employee benefit plan provided by Lyon through the two Respondents; *i.e.*, Capital Blue Cross and Pennsylvania Blue Shield (referred collectively hereinafter as "Respondents" or separately at times as "CBC" and "PBS"). As alleged, CBC was contacted in February of 1993 and asked to pre-authorize the procedure. However, within days of the request, on February 22, 1993, CBC, after reviewing the request, issued written notification to both Ms. Wileman and the Pittsburgh Cancer Institute that preauthorization could not be provided because the requested procedure "would be considered experimental/ investigative and therefore excluded from coverage [under the terms of the plan]. . . ." *See id.* at Exhibit "C", Resp. App. at 40a. Despite this unequivocal denial for pre-authorization, neither Wileman, her mother (Mrs. Garner) nor the Pittsburgh Cancer Institute undertook any steps under ERISA's remedial scheme through the remainder of February, March, April or May to challenge the denial. Nor did Wileman, Garner or the Institute seek relief from any courts under any theories which were *not* ERISA-related.[5]

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4. Respondents will refer to Petitioner's Appendix hereinafter as "Pet. App. __" and their own Appendix as "Resp. App. __".

5. Although Ms. Wileman took no steps to exercise her rights under (Cont'd)

Some four months after the February 22, 1993 denial, Wileman ultimately retained counsel and, following various communications between Wileman and Respondents, CBC agreed in mid-June, 1993 that, on an exception basis, it would agree to authorize the ABMT/HDC treatment. However, at the time CBC had agreed to the granting of the exception, Wileman's employer, unbeknownst to CBC, had already transferred its group coverage from CBC/PBS to GHP. *See* footnote 5, *supra*. In any event, as conceded by Garner in her petition to this Court, when Ms. Wileman presented herself for evaluation at the Pittsburgh Cancer Institute in late June of 1993 (following the granting of the exception), she was no longer a candidate for the ABMT/HDC procedure. *See* Pet. at 5.

Nevertheless, shortly thereafter, Wileman elected to file suit in the Court of Common Pleas of Juniata County, Pennsylvania, against GHP. Then, within days, Wileman elected to file a second state court suit, this time against CBC and PBS. As to CBC and PBS, Wileman contended she was entitled to relief in the form of an order compelling pre-authorization of the desired treatment. She also sought monetary damages under Pennsylvania's "Bad Faith" insurance statute, 42 Pa.C.S. § 8371.[6] (This suit is referred

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(Cont'd)
ERISA for the several month time frame set forth above, two things did occur between the February 22, 1993 denial by CBC and the date suit was first filed against CBC and PBS, that date being July 16, 1993. First, on May 31, 1993, Wileman was terminated from her employment with Lyon. Then, on June 24, 1993, Lyon notified Respondents that, retroactive to June 1, 1993, it (Lyon) was withdrawing from the Respondents' Plan "for pure economic reasons . . ." and, in conjunction therewith, Lyon was making available to its employees alternative group coverage through another insurer, the Geisinger Health Plan ("GHP"), an HMO. Thus, as of June 1, 1993, GHP became the responsible plan for the provision of health benefits to Lyon employees; a responsibility which GHP acknowledged in writing.

6. The verbatim text of 42 Pa. C.S. § 8371 appears at Resp. App. 1a.

to hereinafter as the "Wileman action"). Respondents promptly removed the Wileman action to federal court because her claims clearly "related to" an employee benefit plan and were therefore governed by a federal statute; *i.e.*, ERISA. Thereafter, they filed answers to the Complaint, after which the parties commenced discovery.[7]

On September 15, 1993, Ms. Wileman passed away. *See* Pet. at 5. After her death, the respective attorneys for Ms. Wileman, GHP, CBC and PBS were requested to appear before the district court to discuss the status of the case.[8] By order dated November 3, 1993, the district court ordered Wileman's counsel to provide a status report to the court as to her intentions with regard to the litigation, a report which was to be filed on or before February 4, 1994. This did not occur. Instead, Mrs. Garner, purportedly acting as Administratrix of the Estate of Ms. Wileman, as well as on her own behalf, filed a second suit against CBC and PBS, this time in the Court of Common Pleas of Dauphin County, Pennsylvania. The second action (referred to hereinafter as the "Garner action"), again sought no relief under ERISA. Rather, it sought money damages under (1) 42 Pa.C.S. § 8371 and (2) a host of state common law causes of action such as breach of contract,

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7. In her Petition (Pet. at 5), Garner suggests that the district court erred in not holding an immediate hearing in July of 1993. As conceded by Petitioner, however, by that date, Wileman was no longer a candidate for the ABMT/HDC procedure, and all of the parties and the court knew this; thus, there was no immediacy. *See* Pet. at 5 ("She was no longer a candidate for the treatment").

8. The suit filed against GHP sought similar relief and was similarly removed from state to federal court, GHP contending that, because Ms. Wileman raised claims under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), 29 U.S.C. § 1161, *et seq.*, removal to the federal court system was proper. Wileman never disputed this removal.

breach of fiduciary duty, negligence, fraud, intentional infliction of emotional distress, etc.[9]

On February 14, 1994, Respondents removed the Garner action for the obvious reason that the second action again "related to" an employee benefit plan and, therefore, was governed by ERISA. Indeed, Garner's initial Complaint specifically alleged, *inter alia*, that "Capital Blue Cross and Pennsylvania Blue Shield breached their contracts of insurance with Ms. Wileman and their fiduciary duties to Ms. Wileman by refusing to pay for her bone marrow transplant *in violation of the terms of the contracts of insurance*. . . ."

At or about this same time, Garner filed a Motion to Remand which advanced a single contention. She contended that ERISA did not control her claims against CBC and PBS because Wileman's employer (Lyon) was allegedly not engaged in a "business or activity affecting commerce", a precondition to ERISA applicability. *See* 29 U.S.C. § 1003(a)(1). CBC and PBS opposed the motion by proffering, *inter alia*, excerpts of deposition transcripts of Lyon deponents, as well as a detailed unsworn declaration (as authorized under 28 U.S.C. § 1746) of the plant manager for Lyon, which demonstrated clearly the breadth of the business of Lyon in terms of its effect on interstate commerce.[10] Concurrent with the filing of their papers opposing

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9. Although a copy of the initially filed Garner Complaint does not appear in Respondents' Appendix, a copy of the first Amended Complaint does. *See* Resp. App. at 17a-41a.

10. Petitioner's contention before the district court that Lyon was not engaged in a business or activity affecting commerce was borderline frivolous. For example, Lyon is engaged in the business of manufacturing dresses, blouses and other clothing and, at present, employs approximately 300 individuals. The company leases space at six separate locations in

(Cont'd)

the motion to remand, Respondents filed Rule 12 motions contending that the Garner complaint failed to state a claim upon which relief could be granted.

By Order dated April 15, 1994, the district court disposed of both Garner's Motion to Remand and Respondents' Rule 12 Motions. First, the district court denied Garner's Motion to Remand noting, *inter alia,* that "the Hornberger declaration [Lyon's plant manager] makes it clear that Lyon's is a business that affects interstate commerce . . ." and, thus concluding, that "plaintiff's ground for remand is without merit. . . ." *See* Resp. App. at 10a. Second, the district court denied Respondents' Rule 12 Motions. In doing so, however, the court instructed Garner that she should file an amended complaint "to more clearly indicate which causes of action she [was] pursuing. . . ." As the district court noted:

> There is some confusion among the

(Cont'd)
Pennsylvania, three of which are dedicated to the actual production of the aforesaid goods and products, two of which are not presently in operation, and a sixth which serves as a warehouse and holding unit for the raw materials used in the production of the goods and products. Lyon has employees who are responsible for the transportation of the raw materials from the warehouse to the three production facilities. The majority of the business of Lyon is done on a contract arrangement with one manufacturer which is situated in the state of New York. Lyon receives raw materials, including fabric, from sources outside Pennsylvania and much of the equipment used in the process has its origin from sources outside Pennsylvania. A large percentage of Lyon's goods and products are eventually transported to locations outside Pennsylvania for distribution or sale at retail. Lyon utilizes telephones, telecopiers and the United States mail in conjunction with its operation. The quantity of goods produced by Lyon is substantial, and revenues substantially exceed one million dollars annually. This factual information is all contained within the unsworn declaration of the Lyon plant manager and has been reproduced at Resp. App. at 42a.

> defendants and the court with regard to precisely which causes of action plaintiff asserts. The various counts of the complaint refer to negligence and bad faith. However, the averments quoted *ante*, refer also to breach of contract. *See*, ¶ 26 of the complaint. We suggest that plaintiff amend her complaint to more clearly indicate which causes of action she is pursuing and we *will grant leave to do so*.

Resp. App. at 13a-14a n. 4. (emphasis added).

Subsequently, Garner did file an amended complaint. However, although the district court had denied Garner's sole basis for remand (*i.e.*, ERISA did not apply because Lyon allegedly was not engaged in an industry or activity affecting commerce), her amended complaint continued to be couched in terms of state law causes of action seeking monetary damages only, rather than asserting an entitlement to relief under ERISA (as Petitioner now attempts to do).

Accordingly, as matters stood on April 29, 1994, Respondents were presented with defending against an amended complaint which included eight causes of action including, *inter alia*, breach of contract, negligence, negligent and/or intentional infliction of emotional distress (asserted by Garner in both her personal representative and individual capacity), 42 Pa. C.S. § 8371, common law fraud, and breach of implied covenant of good faith and fair dealing. *See* Resp. App. at 17a-41a.[11]

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11. As to each cause of action asserted, Garner requested damages "in an amount in excess of Fifty Thousand and 00/100 Dollars ($50,000.00), exclusive of interest and costs, plus punitive damages. . . ." *Id.* Nowhere did she seek equitable relief, declaratory relief, or any other form of relief under ERISA.

Respondents filed answers to the amended complaint which raised, *inter alia*, the affirmative defense that the state law claims and requests for damages were preempted and/or barred because each claim "related to" an employee benefit plan and therefore was governed exclusively by ERISA.[12]

On March 11, 1994, counsel for Petitioner and the Respondents met to comply with district court rules requiring the submission of a "Joint Case Management Plan". That Plan, prepared and filed by counsel for Petitioner, again specifically referenced Respondents' intention to file a motion for summary judgment dismissing the first amended complaint, premised upon ERISA's preemption of the state law causes of action. At the same time, Respondents, pursuant to local rule, sought Petitioner's concurrence in the summary judgment motion which, predictably, Petitioner refused. Accordingly, Respondents filed their (1) motions for summary judgment, (2) statement of material facts as to which there is no genuine issue to be tried (as required by local rule) and (3) supporting legal memorandum.

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12. This filing was neither the first nor the last warning provided to Petitioner that her remedy against Respondents, if at all, must be under ERISA and its remedial scheme. In fact, on no less than eight separate occasions, the Respondents had advised Petitioner that her claims, if at all, were governed exclusively by ERISA. *See, e.g.*, (1) Respondents' Notice of Removal in the Wileman action; (2) Respondents' Answer with Affirmative Defenses in the Wileman action; (3) Respondents' Notice of Removal in the Garner action; (4) Respondents' Opposition to Garner's Motion to Remand; (5) Respondents' Answers with Affirmative Defenses to Petitioner's Amended Complaint; (6) the jointly prepared Case Management Plan of May 17, 1994, expressly referencing Respondents' contention that all claims were preempted by ERISA; (7) Respondents' request that Petitioner concur in the Motion for Summary Judgment based upon ERISA preemption; and (8) Respondents' summary judgment motions.

Moreover, as noted, *supra*, the district court itself, in its April 15, 1994 order, specifically instructed, *sua sponte*, that Petitioner file an amended complaint clarifying the nature of her claims.

In the motions, Respondents set forth in detail the reasons why ERISA and its provisions compelled the dismissal of each of the state law claims advanced by Garner. In response, Garner completely failed to address, much less rebut, the majority of the legal arguments advanced in support of the summary judgment motions. Instead, aside from noting that she was preserving for appeal her claim for (1) punitive damages, (2) damages under Pennsylvania's bad faith statute and (3) Garner's individual intentional infliction of emotional distress claim, her opposition brief focused upon the argument that, under ERISA, she *was* entitled to monetary damages. However, even at this juncture, Garner did not file a Rule 15 motion for leave of court to amend her pleadings. Indeed, it was not until the filing of her main brief with the Court of Appeals that Petitioner requested leave to do so.

In order to rebut fully the arguments advanced by Garner in her opposition papers, Respondents nevertheless filed reply briefs with the district court which addressed two points. First, Respondents argued that, because the only causes of action advanced by Petitioner in her amended complaint were state law damage claims, summary judgment was appropriate both because of ERISA's preemption provisions and Garner's apparent abandonment of those claims in her opposition papers. Respondents argued alternatively that, even if the district court were inclined to consider Garner's opposition memorandum as a motion for leave to amend, that motion should nevertheless be denied because (1) the amendments would be futile and subject to a motion to dismiss, and (2) the motion was untimely, would unduly prejudice the Respondents who had developed a defense in response to the *pleaded* state law claims, and would significantly alter the nature of the case and the issues involved.

By order dated July 13, 1994 the summary judgment motions were granted by the district court. In doing so, it made several

findings. First, it reviewed each of the state law claims in light of the applicable law and, in each instance, concluded that the overwhelming weight of authority compelled the conclusion that each of the claims and requests for relief were preempted by and/or inconsistent with ERISA. *See* Opinion, Pet. App. 10a-15a. Second, because Garner never sought leave to amend her amended complaint for the purpose of asserting an ERISA claim, despite being given several opportunities to do so, the court would not construe the amended complaint as asserting an ERISA claim. Third, the district court noted that even if it were inclined to grant leave to amend (for the purpose of pleading a claim for relief under ERISA) such an amendment would be futile because ERISA simply did not permit the type of monetary damages sought by Garner. Specifically, the court noted:

> To the extent that plaintiff seeks to have the court construe her claim as an ERISA action, we decline. Plaintiff has neither sought, nor been granted, leave to amend her Complaint. Fed.R.Civ.P. 15. She has, however, already had the opportunity to amend her Complaint to plead an ERISA case in this court and has not done so. To either construe her claims as an ERISA claim or to allow her to amend at this late date would prejudice the defendants. Further, as noted, ERISA does not contemplate an action such as that brought here. Thus, any amendment would be subject to a motion to dismiss. *Unger v. National Residents Matching Program*, 928 F.2d 1392 (3d Cir. 1991).

Pet. App. at 15a.

Garner's appeal to the Court of Appeals followed. Somewhat

incredibly, Garner argued first in the Court of Appeals that the district court had improperly denied her motion to remand, again contending that Wileman's employer, Lyon, was not engaged in an industry or activity affecting commerce.[13]

More importantly, although Garner asserted a number of state common law causes of action and the single statutory cause of action (*i.e.*, 42 Pa.C.S. § 8371) in the district court, on appeal to the Court of Appeals, she chose to abandon each and every one of those claims except for statutory bad faith.[14] In this regard, the district court's granting of summary judgment as to each of the claims *asserted in the amended complaint* of Garner could have been affirmed by the Court of Appeals simply on the basis of Garner's abandonment of those claims.

Apparently realizing that her state law claims were doomed to fail by reason of ERISA's preemption, Garner, for the first time, requested a court (the Court of Appeals) to grant her leave of court in order to replead her amended complaint for the purpose of asserting claims under ERISA. Respondents argued that, because Garner's request was extremely untimely and prejudicial to Respondents, and the relief she sought was simply not permitted under ERISA in any event, the request for leave to amend should be denied.

The Court of Appeals affirmed the district court noting, *inter alia*, the following:

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13. Although briefed by the parties, counsel for Garner did not raise this issue at oral argument before the Court of Appeals.

14. Given their length, Respondents have not included in their Appendix, a copy of Garner's main and reply briefs filed with the Third Circuit.

> We hold that appellant's claim is preempted by ERISA and thus, we do not need to consider the state law issues raised by appellant. We further find that, although appellant was informed of appellee's position that ERISA preempted her claims and although appellant was given an opportunity by the district court to amend her complaint, she chose not to plead an ERISA claim. Her request now at the appellate level to amend her complaint to plead an ERISA cause of action comes too late.

See Opinion of Court of Appeals, Pet. App. 1a-3a.[15]

It is against this backdrop that Garner asks this Court to review the matter.

REASONS FOR DENYING THE WRIT

1. The Petition presents no special or important reason or consideration which justifies this Court's review of the matter. *See* United States Supreme Court Rule 10. To the contrary, she raises three questions (*see* Pet. at i), none of which justifies review. First, her contention that she should have been granted leave to amend her complaint, upon request at the *appellate* level, is discretionary at best and premised upon and limited to the specific facts of the case. Moreover, the Court of Appeals' handling of this request was wholly appropriate. Second, with regard to her contention that a conflict among the Circuits exists concerning the question whether wrongful death

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15. Garner has yet to explain to any court how Respondents could have moved for summary judgment on an ERISA claim which was *never* pleaded in any complaint or amended complaint. Indeed, summary judgment is to be decided upon a review of the "pleadings, depositions, answers to interrogatories . . . admissions on file, together with affidavits, if any . . . ." (*see* Rule 56(c), Resp. App. 4a).

statutes are subject to preemption, Petitioner completely waived and/or abandoned this contention throughout the proceedings below and, in any event, no conflict exists. [16] Third, although Petitioner did preserve the question of whether the Pennsylvania statutory bad faith insurance claim was preempted by ERISA, the district court's and the Court of Appeals' dismissal of that claim, premised upon ERISA preemption, comports with every decision from the federal courts, including this Court's enunciation in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) and *Mertens v. Hewitt Associates*, __U.S.__, 113 S. Ct. 2063 (1993).

2. **Petitioner's request that this Court assume jurisdiction for the purpose of reviewing the Court of Appeals' refusal to grant leave of court in order to assert an ERISA claim should be denied.** She had numerous opportunities throughout the district court process to amend her pleadings if she had truly wanted to state a claim for relief under ERISA. For reasons which are apparently known only to her, rather than seeking relief under ERISA, she continued to press for compensatory and punitive damages under a host of state law causes of action. Indeed, Garner did so even in the face of repeated warnings from Respondents that they would be seeking summary judgment based on ERISA preemption and in the face of the district court's warning that her initial complaint created "some confusion among the defendants and the court", with the suggestion that she amend the complaint "to more clearly indicate which causes of action she [was] pursuing. . . ." Resp. App. at 13a-14a n. 4.

Although leave to amend is to be granted liberally, an attempt to amend one's pleadings in an appellate brief comes too

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16. This issue will be addressed in more detail, *infra*, at Section 5.

17. *See Guzowski v. Hartman*, 849 F.2d 252, 254 (6th Cir. 1988) (quoting *Hanson v. Town of Flower Mound*, 679 F.2d 497, 504 (5th Cir. 1982); *see also*,

(Cont'd)

late.[17] Again, it is important to bear in mind that this is not a situation where Garner had no reasonable opportunity or ability to assert an ERISA claim. Rather, by the time Respondents had moved for summary judgment in May of 1994, Garner was fully aware that ERISA controlled the disposition of her claim; a claim which had first accrued in February of 1993. In refusing Garner permission for leave to amend, the Court of Appeals acted properly.

3. **Even if the Court of Appeals had permitted Petitioner to amend her Complaint a second time, such an amendment would have been futile and thus subject to dismissal.** The question whether Garner would be entitled to the money damages she sought in this action was laid to rest in this Court's 1993 decision of *Mertens, supra.* There, this Court noted that, regardless of the label which a party seeks to attach to a pleading, claims under § 502(a)(3)(B) of ERISA, 29 U.S.C. § 1132(a)(3)(B) which, *de facto,* seek money damages are, and always have been, precluded by ERISA.[18] Knowing that *Mertens* precludes an award of monetary damages, Garner, in her petition, now seeks to characterize her claim as one for "restitution". *See* Pet. at 13-15. However, to suggest that she sought "restitution" is belied by the history of this case. She consistently sought compensatory and punitive damages only and, in fact, admitted as such; *see, e.g.,* Petitioner's Response to Respondents' Rule 42 Motion to

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(Cont'd)

Pin v. Texaco, Inc., 793 F.2d 1448, 1450 n.4 (5th Cir. 1986) ("The brief on appeal, of course, is not the appropriate place to amend a complaint. . . .").

18. *Accord, Kuhl v. Lincoln Natl. Healthplan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), *cert. denied,* __U.S. __, 114 S. Ct. 694 (1994); *Lafoy v. HMO Colorado*, 988 F.2d 97 (10th Cir. 1993) (holding that a plaintiff's claim for monetary damages, regardless of how characterized, is not cognizable under § 502(a)(3)(B)).

Consolidate at ¶ 3 (the *Garner* action "seeks *damages* resulting from her [Wileman's] death"); ¶ 5 (in *Garner* plaintiff "seeks *damages* arising from the death of Melissa Wileman"); ¶ 13 (The *Garner* action is based upon the death of Melissa Wileman on September 15, 1993, alleging that the actions of Blue Cross and Blue Shield in refusing to pay for the bone marrow transplant for Melissa Wileman increased the risk that she would die as she did and seeking *damages* for her death.).[19]

Garner's attempt to argue that she is entitled to "restitution" in the form of money damages for medical services *never* rendered makes little sense. Moreover, it flies in the face of the plain language of ERISA, and those decisions from this Court interpreting ERISA. It is beyond dispute that ERISA's civil enforcement provision creates an exclusive remedial scheme focusing on the terms of the plan. *See* 29 U.S.C. § 1132(a); *Pilot Life, supra,* 481 U.S. at 54 (ERISA provides that a plan participant or beneficiary may sue to recover benefits, for injunctive relief, and for other relief not relevant here). However, there is simply no language in § 502(a) of ERISA, 29 U.S.C. § 1132(a), or elsewhere which authorizes extra-contractual damages, especially when the claim is premised upon a theory that, *under the terms of the plan,* a beneficiary is entitled to certain benefits.[20]

19. Again, although these pleadings do not appear in the Appendix, they are not in dispute.

20. In arguing that she is entitled to money damages, Garner relies extensively upon *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund,* 12 F.3d 1292 (3d Cir. 1993), a 1993 decision from the United States Court of Appeals for the Third Circuit. Reliance upon *Bixler* is perplexing. At issue in *Bixler* was the viability of a beneficiary's direct action against a plan fiduciary for failure to provide complete and accurate coverage information. Because *Bixler* does not discuss the appropriate parameters of the "other appropriate equitable relief" language of § 502(a)(3)(B), it simply does not support Garner's claim for money damages in this case.

(Cont'd)

4. The Court of Appeals acted properly in concluding that the Pennsylvania "Bad Faith" insurance statute, 42 Pa. C.S. § 8371, is preempted by ERISA. In *Pilot Life, supra,* this Court held that a Mississippi common law claim for a bad faith breach of an insurance contract was preempted by ERISA and that the cause of action was not rescued by the saving clause's "regulates insurance" exception. 481 U.S. at 51-57. In short, this Court held that the bad faith claim did not fit within the McCarran-Ferguson Act's definition of the "business of insurance". *Id.* at 50-51. Indeed, the law of "bad faith" did not spread risk and only tangentially affected the relationship between the insurer and policyholder. *Id.*

As she argued in the Court of Appeals, Garner contends that *Metropolitan Life Insurance Company v. Massachusetts,* 471 U.S. 724 (1985) "mandates a finding that the Pennsylvania bad faith insurance law is not preempted by ERISA. . . ." *See* Pet. at 16. Garner's argument completely ignores this Court's 1987 discussion in *Pilot Life* which distinguished between the facts in *Metropolitan Life* and those alleged in *Pilot Life:*

> In contrast to the mandated-benefits law in *Metropolitan Life,* the [Mississippi] common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in

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(Cont'd)

Additionally, although Garner suggests that the subject panel ignored *Bixler,* Circuit Judge Roth, who authored *Bixler,* is the same Circuit Judge who (1) authored the judgment order in this case, and (2) signed the order denying the petition for rehearing. In short, *Bixler* has no applicability to this action which sought money damages due to an alleged breach of the express terms of the plan.

> certain circumstances allow the policyholder to obtain punitive damages. The state common law of bad faith is, therefore, no more "integral" to the insurer-insured relationship than any state's general contract law is integral to a contract made in that state.

Pilot Life, 481 U.S. at 51.

Garner has been unable to direct this Court to any decision which, subsequent to *Pilot Life*, has held that a bad faith claim, whether common law or statutory, is *not* preempted by ERISA's remedial scheme. Garner's failure to do so is understandable inasmuch as no such decision exists. To the contrary, every federal court which has reviewed bad faith claims subsequent to *Pilot Life* has concluded that such claims "relate to" the ERISA plan, are not saved, and are therefore preempted by ERISA.[21] To hold that state laws of insurance, like the Pennsylvania bad faith statute, qualify for the saving clause exception under ERISA

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21. *See, e.g., Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989) (holding that the provisions of the Texas Insurance Code were preempted by ERISA); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1989), *cert. denied*, 429 U.S. 906 (1989) (holding that claims under the California Insurance Code were preempted by ERISA); *In Re: Life Ins. Co. of North America*, 857 F.2d 1190 (8th Cir. 1988) (holding that a state statute prohibiting the vexatious refusal to pay insurance claims was preempted by ERISA); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453 (10th Cir. 1989) (holding that Colorado's statutory and common law bad faith claims were preempted by ERISA); *Anshcultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988) (holding that Florida's wrongful denial of benefit statute was preempted by ERISA); *Shackelton v. Connecticut General Life Ins. Co.*, 817 F. Supp. 277 (N.D.N.Y. 1993) (holding that New York's statute prohibiting "unfair settlement practices" was preempted by ERISA); and *Juckett v. Beecham Home Improvement Products*, 684 F. Supp. 448 (N.D. Tex. 1988) (holding that the Texas "penalty for delay in payment of losses" statute was preempted by ERISA).

would preserve 50 different state laws of insurance as federal common law, and would, in effect, add an item to the saving clause which this Court has said that Congress did not mean to include. *See Pilot Life*, 481 U.S. at 56 ("the uniformity of decision which the act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws. . . .")

5. There is no conflict among the Circuits as to any claim which Petitioner advanced in this action. In a final effort to have this Court assume jurisdiction, Garner contends *(see* Pet. at 7) that review is appropriate because there exists a conflict among the Circuits relating to her "wrongful death" claim. Presumably, Garner seeks to invoke Rule 10.1(a) of this Court which provides that in reviewing petitions, the Court will consider whether a United States Court of Appeals has rendered a decision in conflict with the decision of another Court of Appeals "on the same matter. . . ." For two compelling reasons, review of this matter is neither appropriate nor necessary.

First, nowhere before the Court of Appeals, or for that matter the district court, did Garner advance *any* argument relating to "wrongful death" or the alleged inapplicability of ERISA preemption as relates to Pennsylvania's wrongful death statute, 42 Pa. C.S. § 8301. Indeed, both the main and reply briefs of Garner in the Court of Appeals contain no reference to the words "wrongful death", let alone a legal argument that preemption is inappropriate because her Pennsylvania wrongful death claim is "too tenuous, remote or peripheral" to the administration of Wileman's employee benefit plan. Indeed, even in her petition for rehearing, Garner raised no issue with regard to the question whether a statutory wrongful death claim is or is not preempted by ERISA. Thus, because this issue was never presented to the Court of Appeals (or the district court), advancing the issue at this

procedural juncture is inappropriate. *See, e.g., G.D. Searle & Co. v. Cohn*, 455 U.S 404, 412 n. 7 (1982) ("Because petitioner did not present this argument to the Court of Appeals, we do not address it. . . ."); *see also, United States v. Ortiz*, 422 U.S. 891, 898 (1975).

Even if this Court were inclined to review the "conflict among the circuits" argument, there simply is no conflict among the Circuits with regard to "the same matter" which was presented to the Court of Appeals and district court below. Instantly, Garner contends that a 1993 decision from the United States Court of Appeals for the Fourth Circuit, *Liberty Corp. v. N.C.N.B. National Bank of South Carolina*, 484 F.2d 1383 (4th Cir. 1993), supports her contention that she is entitled to ignore ERISA's remedial exclusivity and proceed instead in state court with a wrongful death monetary damage claim even though that claim is based upon the alleged improper denial of benefits under the express terms of the plan.[22] For several reasons, the *Liberty Corp.* decision does not present a cognizable conflict among the Circuits with regard to any "same (or similar) matter".

First, *Liberty Corp.* dealt solely with the question whether an anti-subrogation provision which appeared in a North Carolina wrongful death statute precluded a plan administrator from seeking reimbursement of medical expenses advanced by a plan to a decedent. The court, in that case, concluded that ERISA did not preempt the anti-subrogation provision in the North Carolina statute and, therefore, the plan administrator, under North Carolina law, could not be subrogated in an amount which exceeded $1,500.

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22. Garner's entire case centers upon, as it must, her alleged entitlement to preauthorization for the ABMT/HDC procedure under the express terms of her employer's plan. *See* Garner Amended Complaint at ¶ 40, Resp. App. at 25a.

In contrast, here Garner sought money damages *directly against* Respondents because of their alleged wrongful refusal to pre-authorize the ABMT/HDC procedure, a procedure to which Petitioner claimed she was entitled under the express terms of the plan.[23] There can be little doubt that, under the facts presented in this matter, the claims of Garner relate directly to, and arise out of, the employee benefit plan and its terms and conditions of coverage.

Again, Garner has not cited to this Court a single case from any Circuit or district court which has held that, under similar facts, ERISA does *not* preempt claims for monetary damages. The reason Garner has not done so is because the lower courts are universal in their conclusion that, contrary to the assertion of Garner, a state law claim seeking damages for an alleged wrongful denial of benefits under the terms of an ERISA plan "relates to", and is therefore preempted by, ERISA. In short, the Fourth Circuit decision of *Liberty Corp.* presents no conflict among the Circuits as relates to Garner and the claims she seeks to advance. Again, Garner's claims have no relation to the anti-subrogation provision which appears in the North Carolina wrongful death statute and was at issue in *Liberty Corp.*

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23. *See* Amended Complaint at ¶ 40, Resp. App. at 25a ("Defendants Capital Blue Cross and Pennsylvania Blue Shield *breached their contracts of insurance* with Melissa Wileman by . . . acting in an arbitrary and capricious manner in denying and/or delaying pre-authorization for Melissa Wileman's bone marrow transplant. . . .").

Accordingly, there simply is no conflict among the Circuits concerning the "same matter".[24]

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24. At page 7, footnote 1 of the Petition for Writ of Certiorari, Petitioner refers to a number of decisions from various Courts of Appeals, suggesting that those decisions are in conflict with *Liberty Corp.* However, a review of those cases cited by Petitioner confirms that no conflict whatsoever exists. Indeed, the cases cited by Petitioner at page 7, footnote 1, unlike *Liberty Corp.*, involve (similar to the case here) state law wrongful death causes of action for money damages. *See Corcoran v. United Healthcare, Inc.*, 956 F.2d 1321, 1331 (5th Cir. 1992), *cert. denied*, __ U.S. __ , 113 S. Ct. 812 (1992) ("the principle . . . that ERISA preempts state law claims alleging improper handling of benefit claims is broad enough to cover the [wrongful death] action asserted here"); *Tolton v. America Biodyne, Inc.*, 48 F.3d 937, 941 (6th Cir. 1995) (state law claims for wrongful death "that arise from an allegedly improper denial of benefits to an ERISA beneficiary" preempted by ERISA); *Kuhl, supra* (widow's state law claims alleging improper administration of benefits and delay in pre-certification preempted by ERISA); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (7th Cir. 1993), *cert. denied*, __ U.S. __, 114 S. Ct. 1612 (1994) (wrongful death claim based on denial of bone marrow transplant and subsequent death preempted by ERISA); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 510 (10th Cir. 1991) ("Because the facts asserted in support of plaintiff's state law claims, including her wrongful death claim, directly relate to an employee benefit plan covered by ERISA, plaintiff's state law claims are preempted by Section 514(a) of ERISA.).

Lafoy, supra, relied upon by Petitioner, does not involve a claim for wrongful death. Instead, the Tenth Circuit (consistent with *Mertens)* held that an ERISA plan participant may not obtain extra-contractual relief including compensatory damages. Accordingly, *Lafoy* rejects Petitioner's very argument at pages 9-15 of the Petition.

CONCLUSION

For the foregoing reasons, Respondents respectfully request that the Petition for Writ of Certiorari be denied.

Respectfully submitted,

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APPENDIX A — RELEVANT STATUTORY PROVISIONS

42 Pa. C.S. § 8371. Actions on insurance policies

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

(1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.

(2) Award punitive damages against the insurer.

(3) Assess court costs and attorney fees against the insurer.

1990, Feb. 7, P.L. 11, No. 6, 3, effective July 1, 1990.

RULE 15. Amended and Supplemental Pleadings

(a) **Amendments.** A party may amend the party's pleading once as a matter of course at any time before a responsive pleading is served or, if the pleading is one to which no responsive pleading is permitted and the action has not been placed upon the trial calendar, the party may so amend it at any time within 20 days after it is served. Otherwise a party may amend the party's pleading only by leave of court or by written consent of the adverse party; and leave shall be freely given when justice so requires. A party shall plead in response to an amended pleading within the time remaining for response to the original pleading or within 10 days after service of the amended pleading, whichever period may be the longer, unless the court otherwise orders.

Appendix A

(b) Amendments to Conform to the Evidence. When issues not raised by the pleadings are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. Such amendment of the pleadings as may be necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time, even after judgment; but failure so to amend does not affect the result of the trial of these issues. If evidence is objected to at the trial on the ground that it is not within the issues made by the pleadings, the court may allow the pleadings to be amended and shall do so freely when the presentation of the merits of the action will be subserved thereby and the objecting party fails to satisfy the court that the admission of such evidence would prejudice the party in maintaining the party's action or defense upon the merits. The court may grant a continuance to enable the objecting party to meet such evidence.

(c) Relation Back of Amendments. An Amendment of a pleading relates back to the date of the original pleading when

(1) relation back is permitted by the law that provides the statute of limitations applicable to the action, or

(2) the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, or

(3) the amendment changes the party or the naming of the party against whom a claim is asserted if the foregoing provision (2) is satisfied and, within the period provided by Rule 4(m) for service of the summons and complaint, the party to be brought in by amendment (A) has received such notice of the institution of the action that the party will not be prejudiced in

maintaining a defense on the merits, and (B) knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against the party.

The delivery or mailing of process to the United States Attorney, or United States Attorney's designee, or the Attorney General of the United States, or an agency or officer who would have been a proper defendant if named, satisfies the requirement of subparagraphs (A) and (B) of this paragraph (3) with respect to the United States or any agency or officer thereof to be brought into the action as a defendant.

(d) Supplemental Pleadings. Upon motion of a party the court may, upon reasonable notice and upon such terms as are just, permit the party to serve a supplemental pleading setting forth transactions or occurrences or events which have happened since the date of the pleading sought to be supplemented. Permission may be granted even though the original pleading is defective in its statement of a claim for relief or defense. If the court deems it advisable that the adverse party plead to the supplemental pleading, it shall so order, specifying the time therefor.

(As amended Jan. 21, 1963, eff. July 1, 1963; Feb. 28, 1966, eff. July 1, 1966; Mar. 2, 1987, eff. Aug. 1, 1987; Apr. 30, 1991, eff. Dec. 1, 1991; Dec. 9, 1991, Pub.L. 102-198 11(a), 105 Stat. 1626; Apr. 22, 1993, eff. Dec. 1, 1993.)

RULE 56. Summary Judgment

(a) For Claimant. A party seeking to recover upon a claim, counterclaim, or cross-claim or to obtain a declaratory judgment

may, at any time after the expiration of 20 days from the commencement of the action or after service of a motion for summary judgment by the adverse party, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part thereof.

(b) For Defending Party. A party against whom a claim, counterclaim or crossclaim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in the party's favor as to all or any part thereof.

(c) Motion and Proceedings Thereon. The motion shall be served at least 10 days before the time fixed for the hearing. The adverse party prior to the day of hearing may serve opposing affidavits. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

(d) Case Not Fully Adjudicated on Motion. If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a trial is necessary, the court at the hearing of the motion, by examining the pleadings and the evidence before it and by interrogating counsel, shall if practicable ascertain what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. It shall thereupon make an order specifying the facts that appear without substantial controversy, including the

extent to which the amount of damages or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the trial of the action the facts so specified shall be deemed established, and the trial shall be conducted accordingly.

(e) Form of Affidavits; Further Testimony, Defense Required. Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. Sworn or certified copies of all papers or parts thereof referred to in an affidavit shall be attached thereto or served therewith. The court may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, or further affidavits. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the adverse party's pleading, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party.

(f) When Affidavits are Unavailable. Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present by affidavit facts essential to justify the party's opposition, the court may refuse the application for judgment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

(g) Affidavits Made in Bad Faith. Should it appear to the

satisfaction of the court at any time that any of the affidavits presented pursuant to this rule are presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party employing them to pay to the other party the amount of the reasonable expenses which the filing of the affidavits caused the other party to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.

(As amended Dec. 27, 1946, eff. Mar. 19, 1948; Jan. 21, 1963, eff. July 1, 1963; Mar. 2, 1987, eff. Aug. 1, 1987).

APPENDIX B — MEMORANDUM AND ORDER FILED APRIL 15, 1994

IN THE UNITED STATES DISTRICT COUR
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-94-0218

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Plaintiff

vs.

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD,

Defendants

MEMORANDUM

Pending are Plaintiff's motion to remand and Defendants' motions to dismiss and to strike. Fed. R. Civ. P. 12(b)(6) and 12(f).

I. *Facts*

This case arises from the tragic death of Melissa Wileman, a 20-year-old woman who was diagnosed in June, 1992, with peripheral neuroectodermal cancer.[1] Physicians placed Ms. Wileman on chemotherapy and the treatment decreased the size of her tumor by nearly 70 per cent. Her physicians suggested to

1. We draw our description of the facts from the complaint.

her that her only remaining opportunity to entirely eliminate the cancer was to undergo an autologous peripheral stem cell transplant, what is commonly called a bone-marrow transplant.

Ms. Wileman was employed by Lyon Fashions, Inc. ("Lyon"), a clothing manufacturer based in Pennsylvania. Defendant Capital Blue Cross provided benefits to Lyon employees. *See* Plan, Exh. A to complaint. Capital Blue Cross initially declined to precertify the procedure, determining that it was experimental and, therefore, not covered by the Lyon policy. After receiving communication from the Pennsylvania Insurance Department and Ms. Wileman's counsel, Blue Cross reconsidered its earlier position and indicated to Ms. Wileman's counsel that it would pay. It asserted that its decision was based on an exception in the plan and that it continued to believe its earlier refusal was correct. *See* Letter of 6/18/93 from Mary Jane Forbes to Pamela G. Shuman, Esq., Exh. E to complaint.[2] However, while preparing for the bone-marrow transplant in June, 1993, doctors determined that the cancer had grown and that Ms. Wileman was too weak for the transplant. Ms. Wileman died on September 15, 1993.

On January 21, 1994, Plaintiff Erma Garner, individually as Ms. Wileman's mother and as administratrix of her daughter's estate, filed a complaint in the Court of Common Pleas of Dauphin County, Pennsylvania. She alleged causes of action against Capital Blue Cross and Pennsylvania Blue Shield of wrongful death, survivorship, and (although the complaint is regrettably confusing on this point) apparently breach of contract and breach of fiduciary duty. By notice of February 14, 1994,

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2. Although the complaint is vague, apparently Defendant Pennsylvania Blue Shield provided coverage to Lyon employees for physician's charges.

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Defendants removed the case, asserting that it falls within the ambit of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* Plaintiff has moved to remand and Defendants have moved to dismiss.[3]

II. *Law and Discussion*

A. *Motion to Remand*

A case may be removed to federal court if the federal court could have properly exercised jurisdiction over the case when first brought. 28 U.S.C. § 1441(a). After removal, a plaintiff may seek remand to the state court if removal was improper.

Defendants argue that this case involves a federal question because the claims "relate to" an ERISA plan. Plaintiff apparently concedes that this case revolves around an interpretation of the relevant policy language. However, she contends that Lyon was not an employer for purposes of ERISA because it is not "engaged in commerce or in any industry or activity affecting commerce . . ." 29 U.S.C. § 1003(a)(1). Relying solely on the statutory language and *Sheffield v. Allstate Life Insur. Co.*, 756 F. Supp. 309 (S.D. Tex. 1991), Plaintiff asserts that Lyon's business does not affect interstate commerce.

Courts have given a broad interpretation to the phrase "affecting commerce" where it appears in federal legislation. In

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3. By order of March 29, 1994, we consolidated this case with *Wileman v. Capital Blue Cross. et al.*, 1:CV-93-1149. *Wileman* was an action removed from the Court of Common Pleas of Juniata County, Pennsylvania on July 28, 1993. Ms. Wileman was the plaintiff in that action, which sought to force Defendants to provide coverage of the bone-marrow transplant.

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Fugarino v. Hartford Life & Accident Insur. Co., 969 F.2d 178, 183 (6th Cir. 1992), the U.S. Court of Appeals for the Sixth Circuit held that even a "trivial or limited connection or impact upon commerce" was sufficient for ERISA purposes. Indeed, the U.S. Court of Appeals for the Third Circuit has indicated in another context that the phrase "affecting commerce" was intended by Congress to be given its "fullest jurisdictional breadth." *Martin v. United Way of Erie County*, 829 F.2d 445, 448 (3d Cir. 1987), *quoting NLRB v. Reliance Fuel Oil Corp.*, 371 U.S. 224, 226; 83 S.Ct. 312; 9 L.Ed.2d 279 (1963).

Defendants point to the unsworn declaration of the general manager of Lyon, Ronald Hornberger. He explains that the business leases space at six locations in Pennsylvania. Declaration of Ronald Hornberger at ¶ 4. Most of Lyon's business is done with one manufacturer, which is located in New York. *Id.* at ¶ 7. He further indicates that much of the raw material and equipment Lyon uses in its operation comes from sources outside of Pennsylvania. *Id.* at ¶¶ 8 and 9. Finally, a large percentage of Lyon's produced goods and products are transported out of Pennsylvania for retail sale.

We need not dwell long on this question. The Hornberger declaration makes it clear that Lyon is a business that affects interstate commerce, even by a less generous standard than we have described. Even the basic fact that Lyon produces goods that are sold at retail outside of Pennsylvania is sufficient. Thus, we find that Plaintiff's ground for remand is without merit.

B. *Motion to Dismiss*

Our determination regarding remand places us in a peculiar procedural posture. Defendants have removed because they

argue the case arises under ERISA. The current motions, however, attack in substance the common-law claims, purporting to preserve a preemption argument for a later time. *See* Capital Blue Cross's Brief in Support of Motion to Dismiss at 3 n.1. Defendants assert that they will soon submit summary judgment motions arguing the preemption point. Thus, we are asked to address the substance of the common-law claims in the complaint even though they may soon be found preempted. However, because preemption is not given and the issue is not before us, we will consider the motions to dismiss.

Defendants point to five averments of the complaint as relevant to their motion.

> 26. The death of Melissa Wileman was directly and proximately caused by the negligence, bad faith, and breach of contract of the Defendants in refusing to authorize for Melissa Wileman the bone marrow transplant that was her only hope of survival.
>
> 27. By refusing to authorize the bone marrow transplant for Melissa Wileman, the Defendants increased the risk that she would die of cancer as she did.
>
> 28. Defendants deprived Melissa Wileman of the chance to beat the cancer which ultimately caused her death.
>
> * * *
>
> 31. Defendant Capital Blue Cross acted

negligently and in bad faith with respect to Melissa Wileman by:

* * *

(c) Taking from Melissa Wileman the chance that her cancer could be eliminated or arrested to prolong her life:

(d) Increasing the risk that Melissa Wileman would die from cancer...

34. Defendant Pennsylvania Blue Shield acted negligently and in bad faith with respect to Melissa Wileman by:

* * *

(c) Taking from Melissa Wileman the chance that her cancer could be eliminated or arrested to prolong her life;

(d) Increasing the risk that Melissa Wileman would die from cancer;...

Defendants argue that, accepting the assertions as true, they fall short of making out a *prima facie* case because they do not allege that Defendants' conduct was a substantial factor in bringing about Ms. Wileman's death, only a possible factor.

It is true that Pennsylvania law, which would undoubtedly

apply to these claims, requires some greater level of causation than "possibly" or "could have." *Cohen v. Albert Einstein Medical Center*, 405 Pa. Super. 392; 592 A.2d 720, 723 (1991); *see also, Hamil v. Bashline*, 481 Pa. 256, 392 A.2d 1280 (1978).

We see a problem with Defendants' motions. As Plaintiff points out, it would be inappropriate to dismiss a case under Fed. R. Civ. P. 12(b)(6) based on some issue of fact. Looking solely to the complaint, Plaintiff has averred that "[t]he death of Melissa Wileman was directly and proximately caused by the negligence, bad faith, and breach of contract of the Defendants . . ." For purposes of notice pleading, this is sufficient. *Leatherman v. Tarrant County Narcotics Intelligence and Coordination Unit*, __ U.S. __, 113 S.Ct. 1160, 122 L.Ed.2d 517 (1993). Defendants wish us to dismiss these claims based on an interpretation of the language of the complaint least favorable to Plaintiff. This we may not do. In considering a motion under Rule 12(b)(6), we must accept as true all the well-pleaded allegations of the complaint and construe them favorably to the plaintiff. We cannot grant the motion unless the plaintiff can prove no set of facts in support of his claim which would entitle him to relief. *Labov v. Lalley*, 809 F.2d 220 (3d Cir. 1987). Indeed, *Cohen* and *Kravinsky v. Glover*, 263 Pa. Super. 8, 396 A.2d 1349 (1979), on which *Cohen* relies, were both cases in which the Pennsylvania Superior Court considered the sufficiency of expert testimony about causation, holding that the expert must be able to testify with some certainty that the defendant's conduct was a substantial factor in the plaintiff's injury. While such questions about the sufficiency of expert testimony may arise in this case, they are not properly addressed at this stage. We must deny the motions.[4]

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4. There is some confusion among the Defendants and the Court with regard to precisely which causes of action Plaintiff asserts. The various counts of the

(Cont'd)

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C. *Motion to Strike*

Finally, Defendants move to strike averments 36, 40, 41, and 42. Those paragraphs suggest that Defendants have funded experimental procedures for some subscribers and not for others based upon whether the subscribers were prominent in the community and on whether they were represented by counsel. Further, ¶ 42 suggests that Defendants allowed financial concerns to override their duty to treat all claimants similarly.

Defendants request that we strike these averments because they are irrelevant and could cause disclosure of private information about third parties — primarily other patients who are subscribers to other employee welfare plans administered by Defendants. Finally, they argue that the paragraphs will cause unfair attention in the media in a case that may attract public attention.

We can not conclude at this point that the averments are irrelevant. Plaintiff has included a bad faith claim. If Defendants made certification decisions based on prominence or representation, such behavior might rise to the level of bad faith. We disagree with Defendants' contention that this case, as it stands, focuses solely on whether Ms. Wileman's claim was one that should have been paid under the insurance contract. As long as there remains a bad faith claim, Defendants' conduct in making payment decisions remains relevant.

(Cont'd)
complaint refer to negligence and bad faith. However, the averments quoted, *ante*, refer also to breach of contract. *See* ¶ 26 of the complaint. We suggest that Plaintiff amend her complaint to more clearly indicate which causes of action she is pursuing and we will grant leave to do so.

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We appreciate Defendants' two-fold concerns. We agree with Plaintiff, however, that the privacy concerns can be addressed during discovery. Further, we trust that all parties will act responsibly in this matter. We must deny the motion to strike.

We will issue an appropriate order.

s/ William W. Caldwell
William W. Caldwell
United States District Judge

Date: April 15, 1994

Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-94-0218

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased,

Plaintiff

vs.

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD,

Defendants

ORDER

AND NOW, this 15th day of April, 1994, upon consideration of Plaintiff's motion to remand and Defendants' motions to dismiss and to strike, it is ordered that:

1. The motions are denied.

2. If she desires to do so, Plaintiff is granted leave to amend her complaint until April 29, 1994, as per note 4.

s/ William W. Caldwell
William W. Caldwell
United States District Judge

APPENDIX C — AMENDED COMPLAINT (WITH EXHIBIT C ONLY)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

NO. 1:CV-94-0218

Assigned to: Judge Caldwell

ERMA GARNER, Individually and as Administratrix of the Estate of Melissa Wileman,

Plaintiff

v.

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD,

Defendants

NO. 1:CV-93-1149

MELISSA WILEMAN,

Plaintiff

CAPITAL BLUE CROSS and PENNSYLVANIA BLUE SHIELD

Defendants

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AMENDED COMPLAINT

1. Plaintiff Erma Garner is the mother and Administratrix of the Estate of Melissa Wileman, by Letters of Administration to her by the Register of Wills of Juniata County, Pennsylvania, and she is an adult resident of Juniata County, Pennsylvania.

2. Defendant Capital Blue Cross is a corporate health insurer with offices in Harrisburg, Dauphin County, Pennsylvania, and doing business throughout central Pennsylvania, including Dauphin County, Pennsylvania.

3. Defendant Pennsylvania Blue Shield is a corporate health insurer with offices in Camp Hill, Cumberland County, Pennsylvania, and doing business throughout central Pennsylvania, including Dauphin County, Pennsylvania.

4. At all times relevant to this Complaint, Defendants Blue Cross and Blue Shield were the contractual health insurers for Melissa Wileman. Copies of the contracts are attached hereto as Exhibits A and B.

5. In June, 1992, Melissa Wileman, age 20, was diagnosed with peripheral neuroectodermal cancer.

6. Melissa was placed on a regimen of chemotherapy, to which she responded well.

7. By late 1992, nearly 70% of Melissa Wileman's tumor was gone, she was pain free, and she was able to go about her daily activities normally.

8. Ms. Wileman's doctors recommended that the only

treatment that had the possibility of eliminating her cancer was an autologous peripheral stem cell transplant, commonly called a bone marrow transplant, since she had obtained the maximum benefit from chemotherapy.

9. Melissa's doctors believed she was an excellent candidate for the procedure since she had responded so well to chemotherapy, and childhood sarcomas, similar to her cancer, respond well to bone marrow transplants.

10. When contacted for pre-authorization, Defendant Blue Cross indicated that Ms. Wileman had to be out of the hospital for sixty days before the bone marrow transplant could be performed.

11. Although Ms. Wileman had previously been undergoing chemotherapy in the hospital, such chemotherapy was halted so that the sixty day requirement of Defendant Blue Cross could be met.

12. Despite the fact that one of the basic Blue Cross benefits available to Ms. Wileman was "tissue transplant services," see p. 8 of Exhibit A, in late February, 1992, Defendant Blue Cross denied Ms. Wileman's request for pre-authorization for the bone marrow transplant stating "we note that the autologous bone marrow transplant would be considered experimental/ investigative and therefore excluded from coverage." See Blue Cross letter dated February 22, 1993, attached hereto as Exhibit C.

13. Such a decision by the very insurer who would have to pay out the funds for the procedure represents a clear conflict of interest, with strong pressures on the insurer to deny the claim and keep its coffers full.

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14. Ms. Wileman's treating oncologist, Dr. Ricardo Carter, tried to reach Blue Cross administrators to discuss its denial of authorization for this procedure for Ms. Wileman, without success.

15. Mrs. Garner, on behalf of her daughter, contacted her state Senator and later Governor Casey's office about the denial.

16. Governor Casey's office referred Mrs. Garner's inquiry to the Insurance Department which wrote to Defendant Blue Cross on April 22, 1993.

17. Nearly a month later, Blue Cross offered an "apology for the delay in our response" and denied pre-authorization for Melissa Wileman based on "the investigative status of this procedure for persons with neuroectodermal tumor." See letter from Blue Cross dated May 20, 1993, attached hereto as Exhibit D.

18. By letter dated May 26, 1993, the Insurance Department wrote to Mrs. Garner: "The crux of this problem involves making medical determinations to establish eligibility for benefits. However, the Pennsylvania Insurance Department has neither the expertise or legal authority to make such determinations." The letter went on: "You may wish to seek legal counsel for further advice." See letter dated May 26, 1993, attached hereto as Exhibit E

19. In early June, 1993, Ms. Wileman retained counsel who contacted Blue Cross.

20. By letter dated June 7, 1993, Ms. Wileman's attorney wrote to Blue Cross:

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It is my understanding that Blue Cross has already been provided with documentation from the University of Pittsburgh Medical Center and from oncologist Richardo Carter, M.D., establishing that peripheral stem cell transplant has been very successful in treating soft tissue carcinomas similar to Melissa's. Because the type of cancer that Melissa has is extremely rare, it is doubtful that there will ever be an established protocol based upon study groups establishing the efficacy of peripheral stem cell transplant specifically in relation to periapical neuroectodermal carcinoma.

It is our understanding that the treatment is no longer experimental or investigative and that Blue Cross is responsible to pay the costs involved in it. Please contact me within ten days of the date of this letter to discuss this matter if Blue Cross is willing to pay for the procedure Missy needs. Otherwise, we will have no choice but to bring suit against Blue Cross, alleging not only contractual breach but also asserting a claim for punitive damages and attorney's fees based upon Blue Cross' bad faith in handling this claim that involves the only life-saving treatment available.

A copy of Plaintiff's counsel's June 7, 2993 letter is attached hereto as Exhibit F.

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21. By letter dated June 18, 1993, ten days after receipt of Plaintiff's attorney's letter, counsel for Blue Cross wrote:

> The purpose of this letter is to confirm our telephone conversation on Thursday, June 17, 1993, during which I informed you that Capital Blue Cross ("CBC") had reconsidered its decision to deny the request for preauthorization for a peripheral stem cell transplant for your client, Melissa Wileman. The denial of the request for preauthorization had been communicated most recently by our letter dated May 20, 1993 to Harold Smith at the Pennsylvania Insurance Department.
>
> After further review, CBC has determined that it will provide coverage under Ms. Wileman's Blue Cross contract on an exception basis. Although we continue to believe our initial conclusion that the peripheral stem cell transplant proposed for Ms. Wileman was excluded from coverage because it is an experimental/investigative procedure, was proper, we are nonetheless authorizing coverage for this procedure for Ms. Wileman on an exception basis for several reasons. These include, but are not limited to, our desire to avoid the expense and other risks of litigation and the glare of publicity that such suits frequently provoke.

A copy of the June 18, 1993 letter from Blue Cross is attached hereto as Exhibit G.

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22. Defendant Blue Shield was also contacted with regard to pre-authorization by Ms. Wileman's attorneys.

23. When Defendant Blue Shield learned that Defendant Blue Cross had authorized the procedure, Defendant Blue Shield indicated that if suit were started against it by Writ of Summons, an emergency decision could be made to pay the doctor component of costs involved in the bone marrow transplant.

24. During Blue Cross/Blue Shield's delay from February to June, 1993, Melissa Wileman went from remission to active disease.

25. Subsequent evaluation in late June, 1993, preliminary to performance of the bone marrow transplant demonstrated that Ms. Wileman was no longer in remission, her cancer was growing, and she was then too weak to undergo the bone marrow transplant.

26. Plaintiff believes and avers that it was the policy of Blue Cross/Blue Shield to refuse payment for such transplants unless and until the insured obtained counsel whereupon Blue Cross/ Blue Shield would pay for the very same services they denied. If contract holders did not obtain counsel immediately such approval would be delayed often with fatal consequences.

27. Throughout July, August, and September, 1993, Melissa Wileman deteriorated, suffering agonizing pain as the cancer spread and the tumors grew.

28. Because of the chemotherapy she had had, Ms. Wileman became unable to fight infection, developed multiple blood infections, and required extensive hospitalization.

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29. Because of the excruciating pain she experienced, Ms. Wileman was on intravenous morphine.

30. On September 15, 1993, at approximately 9:45 a.m., Melissa Wileman died as a result of cancer at the age of 21.

31. The death of Melissa Wileman was directly and proximately caused by the negligence, bad faith, breach of contract, tortious interference with the contractual relationship between Ms. Wileman and her health care providers in arbitrarily and capriciously refusing to authorize for Melissa Wileman the bone marrow transplant that was her only hope of survival.

32. By arbitrarily and capriciously refusing to authorize the bone marrow transplant for Melissa Wileman, the Defendants put their own interests ahead of those of their insured.

33. The Defendants' actions in delaying life-saving treatment thus were a substantial factor in bringing about the death of Melissa Wileman.

34. By refusing to authorize the bone marrow transplant for Melissa Wileman, the Defendants acted arbitrarily and capriciously.

35. The Defendants' actions represent negligent and/or intentional infliction of emotional distress.

36. Defendants' conduct demonstrates bad faith, outrageous actions and/or actions done in reckless indifference to the interests of Melissa Wileman, warranting punitive damages.

37. Defendants systematically and consciously

discriminated between contract holders who obtained counsel and those who did not in authorizing payment for the same treatments all in an effort to maximize Blue Cross/Blue Shield's economic position.

COUNT I

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

38. Paragraphs one through 37 of the Complaint are incorporated herein by reference.

39. At all relevant times herein, Defendant Capital Blue Cross was acting as agent, apparent agent, servant and/or employee of Defendant Pennsylvania Blue Shield.

40. Defendants Capital Blue Cross and Pennsylvania Blue Shield breached their contracts of insurance with Melissa Wileman by:

(a) failing to authorize the bone marrow transplant when it was recommended in January, 1993;

(b) paying for other treatment for Melissa Wileman's peripheral neuroectodermal cancer but denying her the bone marrow transplant as investigative;

(c) denying to Melissa Wileman the bone marrow transplant, which denial was a substantial factor in the death of Melissa Wileman;

(d) purposefully delaying in authorizing the bone marrow transplant until Ms. Wileman obtained an attorney, by which time Melissa Wileman was no longer a candidate for the procedure;

(e) acting in an arbitrary and capricious manner in denying and/or delaying pre-authorization for Melissa Wileman's bone marrow transplant, thereby breaching the duty of good faith that underlies the contract; and

(f) systematically discriminating between similarly situated policy holders on the basis of whether they obtained legal counsel and/or promised publicity.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

COUNT II

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

41. Paragraphs one through 37 and Count I of this Complaint are incorporated herein by reference.

42. At all relevant times herein, Defendant Capital Blue Cross was acting as agent, apparent agent, servant and/or employee of Defendant Pennsylvania Blue Shield.

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43. Defendants Capital Blue Cross and Pennsylvania Blue Shield acted negligently with respect to Melissa Wileman by:

(a) failing to authorize the bone marrow transplant when it was recommended in January, 1993;

(b) paying for other treatment for Melissa Wileman's cancer but denying her the bone marrow transplant as investigative;

(c) unreasonably delaying pre-authorization for the bone marrow transplant in the winter of 1993, while agreeing to pre-authorization in June, 1993, as soon as an attorney became involved, by which time Melissa Wileman was too sick to undergo the procedure.

(d) denying to Melissa Wileman the bone marrow transplant, which denial was a substantial factor in the death of Melissa Wileman;

(e) purposefully delaying in authorizing the bone marrow transplant until Ms. Wileman obtained an attorney, by which time Melissa Wileman was no longer a candidate for the procedure;

(f) acting in an arbitrary and capricious manner in denying and/or pre-authorization for Melissa Wileman's bone marrow transplant, thereby breaching the duty of good faith that underlies the contract; and

(g) systematically discriminating between similarly situated policy holders on the basis of whether they obtained legal counsel and/or promised publicity.

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44. The Defendants' negligence was a substantial factor in causing the death of Melissa Wileman.

45. The Defendants' negligence increased the risk that Melissa Wileman would die from cancer, as she did.

46. Moreover, the Defendants were negligent in acting arbitrarily and capriciously in denying and/or delaying precertification to Melissa Wileman while pre-authorizing payment for the same procedure for other subscribers.

47. The Defendants were negligent in acting capriciously and arbitrarily in denying and/or delaying pre-certification of the bone marrow transplant for Ms. Wileman on the basis that the treatment was investigative, while paying for other procedures that truly were "investigative" for other subscribers.

48. The Defendants were negligent in denying and/or delaying pre-certification for the bone marrow transplant for Melissa Wileman despite this treatment's efficacy in treating tumors in the same category as Ms. Wileman's.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

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COUNT III

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

49. Paragraphs one through 37 of the Complaint and Counts I and II are incorporated herein by reference.

50. The Defendants are responsible for the negligent and/or intentional infliction of emotional distress suffered by both Melissa Wileman and Erma Garner based upon their contemporary sensory perceptions of the Defendants' negligent denial and/or delay in granting pre-authorization for Melissa Wileman's bone marrow transplant.

51. Upon notice of the denial of pre-authorization for the bone marrow transplant, both Melissa Wileman and her mother, Erma Garner, suffered physical injury in the form of increased blood pressure, sweating, nausea, racing heartbeat, hyperventilation, and other similar physical manifestations.

52. Moreover, the Defendants knew that their actions would or likely would cause extreme emotional distress to Melissa Wileman and her mother.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration as well as punitive damages based upon the Defendants' outrageous conduct.

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COUNT IV

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

53. Paragraphs one through 37 of the Complaint and Counts I, II and III are incorporated herein by reference.

54. The Defendants' actions constitute bad faith under 42 Pa. C.S. 8371.

55. Under that Pennsylvania Insurance Statute, which is exempt from ERISA pre-emption under the ERISA Insurance Savings Clause, the Plaintiff is entitled to the cost of the bone marrow transplant, Two Hundred and Fifty Thousand Dollars ($250,000.00), interest on that amount from January, 1993 at the prime rate plus three percent (3%), punitive damages, court costs, and attorney's fees.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, plus punitive damages, courts costs, attorney's fees, and interest from January, 1993 equal to the prime rate plus three percent (3%).

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COUNT V

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

56. Paragraphs one through 37 of the Complaint and Counts I, II, III and IV are incorporated herein by reference.

57. The Defendants' actions in denying and/or delaying preauthorization for Melissa Wileman for a bone marrow transplant amount to fraud, since the contract of insurance provides for payment of expenses associated with transplantation and a bone marrow transplant is not an investigative procedure.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration, as well as punitive damages.

COUNT VI

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

58. Paragraphs one through 37 of the Complaint and Counts I, II, III, IV and V are incorporated herein by reference.

59. The Blue Cross and Blue Shield policies of insurance indicate that they cover transplants.

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60. The University of Pittsburgh Cancer Center determined that Melissa Wileman satisfied the medical criteria required by it to perform the transplant.

61. The Defendants unreasonably and without full investigation determined that the subject transplant was investigative and unreasonably withheld approval of the procedure in breach of the insurance contract.

62. At all times herein mentioned, Melissa Wileman performed all of the terms and conditions of the insurance policies on her part.

63. Ms. Wileman and her doctors timely and properly requested that the Defendants provide coverage for the bone marrow transplant.

64. The Defendants denied coverage claiming that the procedure sought was "investigative." Bone marrow transplants, however, are not "investigative."

65. Based on the language of the insurance policy and on representations made by employees of the Defendants, Melissa Wileman reasonably anticipated that the policy would cover a lifesaving bone marrow transplant recommended for her by her health care providers.

66. Despite all of the above, the Defendants refused to provide coverage to Ms. Wileman under the policies for a lifesaving bone marrow transplant.

67. The Defendants had no valid reason for refusing to provide coverage. Once an attorney became involved in the case,

the Defendants changed their position, agreeing to the bone marrow transplant without any additional information in front of them except a letter from an attorney representing Ms. Wileman.

68. The Defendants' conduct constitutes a conscious disregard of Ms. Wileman's rights, thereby breaching the covenant of good faith and fair dealing implied in the insurance contracts provided by the Defendants to her.

69. These intentional breaches of the covenant of good faith and fair dealing were a substantial factor in the death of Melissa Wileman.

70. Moreover, the Defendants' discriminatory policies and practices in treating its insureds differently based on whether they have attorneys or are likely to gain public attention represent a breach of the covenant of good faith and fair dealing.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

COUNT VII

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

71. Paragraphs one through 37 of the Complaint and Counts I, II, III, IV, V and VI are incorporated herein by reference.

72. The negligent conduct of the Defendants is outrageous and beyond all bounds of decency.

73. The Defendants' conduct in failing to pre-authorize the bone marrow transplant and delaying approval of it until after Ms. Wileman retained an attorney and was too sick to undergo it caused both Ms. Wileman and Mrs. Garner to suffer the highest levels of severe emotional distress, shock, horror, grief, anger, disappointment, and worry.

74. The emotional distress suffered by Melissa Wileman and Erma Garner, as well as the physical injuries including illness and death suffered by Melissa Wileman were foreseeable results of the Defendants' negligent conduct.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

COUNT VIII

Erma Garner, Individually and as Administratrix of the Estate of Melissa Wileman, Deceased v. Capital Blue Cross and Pennsylvania Blue Shield

75. Paragraphs one through 37 of the Complaint and Counts I, II, III, IV, V, VI and VII are incorporated herein by reference.

76. The Defendants knew or should have known that their intentional conduct was outrageous and beyond all bounds of

decency and would cause Melissa Wileman and her mother to suffer the highest levels of severe emotional distress, shock, horror, grief, anger, disappointment, worry, physical injury, illness and death for Melissa Wileman.

77. The Plaintiffs' injuries and emotional distress were a foreseeable result of the Defendants' intentional conduct.

78. Erma Garner and the Estate of Melissa Wileman and Melissa Wileman were significantly damaged by the Defendants' intentional infliction of emotional stress.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration, and punitive damages.

CLAIM I – Wrongful Death

79. Paragraphs one through 37 and Counts I, II, III, IV, V, VI, VII and VIII of the Complaint are incorporated herein by reference.

80. Erma Garner brings this action for wrongful death on her own behalf and on behalf of all other persons who may be entitled to share in damages as listed below:

Erma Garner – surviving parent
R.D. #2, Box 334, Millerstown, Pa. 17062

Lawrence Garner – surviving parent
R.D. #2, Box 334, Millerstown, Pa. 17062

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81. During her lifetime, Melissa Wileman did not commence an action to recover damages for the injuries which caused her death, and no other action has been filed to recover damages for the wrongful death of Melissa Wileman.

82. At the time of her death, Melissa Wileman was 21 years old, having been born on May 26, 1972.

83. Defendants Capital Blue Cross and Pennsylvania Blue Shield are liable to the aforenamed beneficiaries of Melissa Wileman, for damages as set forth herein.

84. As a result of the death of the decedent, her parents as identified above, have suffered pecuniary loss, both have been deprived of her contribution, support, and services in the past and in the future will be deprived of the decedent's contribution, support, and services, and claim is made therefor, as well as claim for any other damages which are recoverable under the Wrongful Death Act.

85. As a result of the death of Melissa Wileman, her parents have incurred medical, funeral, burial, and related expenses, for all of which claim is made.

WHEREFORE, Erma Garner, individually and as Administratrix of the Estate of Melissa Wileman, deceased, claims judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

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CLAIM II – Survival Action

86. Paragraphs one through 37, Counts I, II, III, IV, V, VI, VI, VIII and Claim I are incorporated herein by reference.

87. Plaintiff Erma Garner brings this action on behalf of the Estate of Melissa Wileman, deceased, under and by virtue of the Act of 1976, July 9, P.L. 586, No. 142, 2,42 Pa. C.S. 8302.

88. Defendants Capital Blue Cross and Pennsylvania Blue Shield are liable to the Estate of Melissa Wileman, deceased, for damages as set forth herein.

89. Plaintiff Erma Garner, Administratrix of the Estate of Melissa Wileman, deceased, claims on behalf of said Estate by reason of the death of the decedent for pain and suffering the decedent underwent prior to her death, loss of earnings and earning capacity for decedent's life expectancy, and for all other damages sustained by the said Estate by reason of the death of the decedent.

WHEREFORE, Erma Garner, individually and as Administratrix of the Estate of Melissa Wileman, deceased, claims judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, and in excess of any jurisdictional amount requiring compulsory arbitration.

CLAIM III – Bad Faith

90. Paragraphs one through 31, Counts I, II, III, IV, V, VI, VII, VIII, Claims I and II are incorporated herein by reference.

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91. Under 42 Pa. C.S. 8371, Plaintiffs are entitled to punitive damages, interest at a rate of three percent (3%) over the prime rate since January, 1993, punitive damages, attorney's fees and costs, in addition to the costs of the procedure of Two Hundred and Fifty Thousand Dollars ($250,000.00).

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, plus punitive damages, court costs, attorney's fees, and interest from January, 1993 equal to the prime rate plus three percent (3%).

CLAIM IV – Emotional Distress

92. Paragraphs one through 31, Counts I, II, III, IV, V, VI, VII, VIII, Claims I, II and III are incorporated herein by reference.

93. Based upon the negligent and/or intentional infliction of emotional distress, Plaintiffs are entitled to compensation from the Defendants for the emotional distress suffered plus punitive damages, attorney's fees and costs.

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants Capital Blue Cross and Pennsylvania Blue Shield in an amount in excess of Fifty Thousand Dollars ($50,000.00), exclusive of interest and costs, plus punitive damages.

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RESPECTFULLY SUBMITTED,

ANGINO & ROVNER, P.C.

s/ Pamela G. Shuman
Pamela G. Shuman, Esquire
I.D. No. 41696
4503 North Front Street
Harrisburg, PA 17110
(717) 238-6791
Counsel for Plaintiff

Dated: April 29, 1994

Appendix C

EXHIBIT C

Capital Blue Cross
Agent for Pennsylvania Blue Shield

Harrisburg, PA 17177
(717) 541-7000

February 22, 1993

MS SHANNA POLLOCK RN
TRANSPLANT COORDINATOR LIAISON
UNIVERSITY OF PITTSBURGH MEDICAL CENTER
DESOTO AT OHARA STREETS
PITTSBURGH PA 15213-2582

Re:	Patient:	MELISSA L WILEMAN
	Identification #:	195 56 7721
	Group #:	022122005

Dear Ms. Pollock:

This is to confirm my telephone conversation regarding coverage for Autologous Bone Marrow Transplant for Melissa L. Wileman.

According to the terms of Ms. Wileman's Blue Cross Contract, we note that the Autologous Bone Marrow Transplant would be considered experimental/investigative and therefore excluded from coverage.

If you have any questions don't hesitate to contact me at (717) 541-6351.

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Sincerely,

s/ Constance Hughes, R.N.
Constance Hughes RN
Benefits Management/Quality Assessment

dgh/43/23

cc: Ms. Melissa L. Wileman
R D # 2 Box 334
Millerstown PA 17062

APPENDIX D — UNSWORN DECLARATION

UNSWORN DECLARATION

I hereby verify that I am authorized to execute this unsworn declaration on behalf of Lyon Fashions, Inc. and that the following statements are true and correct and based upon personal knowledge.

1. I am the General Manager responsible for the day-to-day operation of Lyon Fashions, Inc., a Pennsylvania corporation.

2. Lyon Fashions, Inc. is engaged in the business of contracting dresses, blouses and other clothing for a manufacturer.

3. At present Lyon Fashions, Inc. employs approximately 300 employees.

4. At present Lyon Fashions, Inc. leases space at six separate locations in Pennsylvania, with corporate offices located in McAllisterville, Pennsylvania.

5. Three of the locations are involved in the production of the aforesaid goods and products; two of the locations are not presently in operation; the sixth location, situate at East Salem, Pennsylvania, is a warehouse and holding unit for raw materials used in producing the aforesaid goods and products.

6. Lyon Fashions, Inc. has employees who are responsible for the transportation of the raw materials from the warehouse to the three locations producing the aforesaid goods and products.

7. The majority of the business of Lyon Fashions, Inc. is done on a contract arrangement with one manufacturer, who is situated in the State of New York.

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8. In connection with the business of Lyon Fashions, Inc. it receives raw materials, including fabric, whose origin is from sources outside Pennsylvania.

9. Additionally, much of the equipment used in the contracting process has its origin from sources outside Pennsylvania.

10. A large percentage of its produced goods and products are eventually transported to a location outside Pennsylvania for distribution or sale at retail.

11. Lyon Fashions, Inc. utilized telephones, telecopiers and the United States mails in conjunction with the operation of its business and the telephone, telecopier and mails involve communications with individuals and entities outside of Pennsylvania.

12. The quantity of goods produced by Lyon Fashions, Inc. is substantial and the revenues received by Lyon Fashions, Inc. pursuant to the aforesaid contracts is substantial; that amount substantially exceeding $1 million.

I hereby verify that the foregoing is true and correct and based upon personal knowledge, I declare and verify under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct.

s/ Ronald S. Hornberger
(name)

Dated: September 10, 1993